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# MEDICARE COVERAGE OF EMERGENCY RESPONSE SYSTEMS AND DIRECT REIMBURSEMENT OF MENTAL HEALTH SPECIALISTS

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## HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

SECOND SESSION

ON

## H.R. 3921

TO AMEND TITLE XVII OF THE SOCIAL SECURITY ACT TO PROVIDE MEDICARE COVERAGE OF PERSONAL EMERGENCY RESPONSE SERVICES

AND

## H.R. 6092

TO AMEND TITLES XVIII AND XIX OF THE SOCIAL SECURITY ACT TO PROVIDE MORE ADEQUATE COVERAGE OF THE SERVICES OF MENTAL HEALTH SPECIALISTS UNDER THE MEDICARE SUPPLEMENTAL BENEFITS PROGRAM AND UNDER MEDICAID PROGRAMS

DECEMBER 14, 1982

**Serial 97-87**

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# MEDICARE COVERAGE OF EMERGENCY RESPONSE SYSTEMS AND DIRECT REIMBURSEMENT OF MENTAL HEALTH SPECIALISTS

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## TUESDAY, DECEMBER 14, 1982

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
*Washington, D.C.*

The subcommittee met at 11:05 a.m., pursuant to notice, in room B-318, Rayburn House Office Building, Hon. Andy Jacobs, Jr. (chairman of the subcommittee) presiding.

[The press releases announcing the hearing follow:]

[Press release of Tuesday, Nov. 30, 1982]

### Hon. Andy Jacobs, Jr., Announces a Hearing To Examine Proposals To Provide Medicare Coverage of Personal Emergency Response Systems and Proposals To Provide Direct Reimbursement of Services Provided by Mental Health Specialists, Tentatively Scheduled for December 14, 1982

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a public hearing tentatively scheduled for Tuesday, December 14, 1982. The date of the hearing may have to be changed depending on the schedule of the Committee. The hearing will examine two medicare issues: to provide coverage for personal emergency response services; and to provide direct reimbursement for services provided by mental health specialists. The hearing will be held in room B-318, Rayburn House Office Building beginning at 10 a.m.

#### BACKGROUND

*Personal Emergency Response Services.*—The Subcommittee is interested in hearing testimony on issues related to coverage of personal emergency response services under the medicare program. The personal emergency response systems available vary widely. However, the basic purpose of all of the systems is to provide a home emergency alarm system which, if activated, would sound an alert that the individual is experiencing an emergency in his home, and would in some way summon assistance.

Under current law medicare does not cover personal emergency response services. However, H.R. 3921, introduced by Mrs. Heckler and Mr. Pepper, et al., would provide coverage of such services under the supplementary medical insurance (SMI) part of the medicare program. To qualify for the new benefit, an individual would have to be both severely functionally impaired and either living alone or likely to be left alone for substantial periods of time. Reimbursement would be subject to the usual deductible and coinsurance requirements of the medicare program.

*Direct Reimbursement for Mental Health Practitioners.*—The Subcommittee, in addition, is interested in hearing testimony regarding a proposal to provide direct reimbursement under the medicare program for mental health services provided by mental health practitioners.

Under current law, a physician, generally, is the only mental health provider who may receive reimbursement directly. Reimbursement to mental health practitioners may be allowed if the services provided are either incident to a physician's service or if the practitioner is an employee, for example, of a hospital.

H.R 6092, introduced by Mr. Fithian, et al., would amend the supplementary medical insurance (SMI) part of the medicare program, and the medicaid program, to provide direct reimbursement for covered mental health services provided by clinical psychologists, clinical social workers, psychiatric nurse specialists and, psychiatrists. In addition, the bill would define minimum education and other standards. Reimbursement would be subject to the usual deductible and coinsurance requirements of the medicare program.

### DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Individuals and organizations interested in presenting oral testimony at the hearing should submit their requests to be heard by telephone to Harriett Lawler [telephone (202) 225-3627] no later than noon, Thursday, December 9, 1982, to be followed by a formal written request to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. Notification to those scheduled to appear will be made by telephone as soon as possible after the filing deadline.

Requests to be heard must contain the following information:

(1) The name, address, title, firm affiliation and/or organization the witness will represent (as well as a telephone number where he or his designated representative may be reached);

(2) If appearing in an individual capacity, a list of any clients at whose request or in whose employ the witness appears; and

(3) A topical outline or summary of comments and recommendations.

The above information should also be incorporated in the prepared statements to be presented in person as well as those filed for the written record of the hearing.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, witnesses scheduled to appear before the Subcommittee are required to submit 50 copies of their prepared statement to the full Committee office, room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

### WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, five copies are required and may be submitted to the Committee office by the close of business Friday, January 21, 1983. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the committee office before the hearing begins.

[Press release of Friday, Dec. 10, 1982]

## HON. ANDY JACOBS, JR., ANNOUNCES A CHANGE IN TIME OF A PREVIOUSLY ANNOUNCED HEARING TO EXAMINE PROPOSALS TO PROVIDE MEDICARE COVERAGE OF PERSONAL EMERGENCY RESPONSE SYSTEMS AND PROPOSALS TO PROVIDE DIRECT REIMBURSEMENT OF SERVICES PROVIDED BY MENTAL HEALTH SPECIALISTS SCHEDULED FOR DECEMBER 14, 1982

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, today announced a change in time for the Subcommittee's previously announced hearing to examine two medicare issues: to provide coverage for personal emergency response services; and to provide direct reimbursement for services provided by mental health specialists. The hearing will be held in room B-318, Rayburn House Office Building beginning at 11 a.m.

Those individuals and organizations who have filed requests to testify by December 9, 1982, in accordance with the Chairman's press release of November 30, 1982 (Health PR No. 9), will be scheduled as witnesses. No additional witnesses can be accommodated on the hearing schedule if requests were not received by the Committee by December 9, 1982. Witnesses are reminded to submit at least 50 copies of their testimony to the Committee office, room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance.

### WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the record of the hearing, five copies are required and may be submitted through the close of business, January 31, 1983, to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Committee office before the hearing begins.

Chairman JACOBS. If the clerk will note for the record, the hearing is in session.

The first witness is our colleague, Representative Floyd Fithian of Indiana. And he knows he is welcome but for the record, he is very welcome.

## STATEMENT OF HON. FLOYD J. FITHIAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. FITHIAN. Thank you, Mr. Chairman, and let me compliment you for this hearing in what I consider to be a very vital element of the whole health care picture in this country. Even at this 11th hour when lots of other things are happening on the Hill, I recognize the pressures under which this subcommittee is placed.

I, therefore, doubly thank you for affording those of us interested in this legislation an opportunity to be heard.

The bill which I am proud to say I originally sponsored in April of this year now has some 22 cosponsors, and while I will not be here to give it any additional push next year, may I leave this baby on your doorstep and urge you to give it every consideration before the subcommittee and the full committee.

Chairman JACOBS. I would think this wish would keep it rolling for at least 2 years.

Mr. FITHIAN. As you know, Mr. Chairman, this would amend titles 18 and 19 of the Social Security Act to make the mental health services of clinical psychologists, social workers and psychiatric nurse specialists directly reimbursable without physician supervision or referral. The purpose of the bill is to offer the elderly and low-income beneficiaries a greater option in their search for a mental health provider, and to save very valuable health dollars.

I suspect, Mr. Chairman, in the course of the hearings today and later, that you may have that particular point argued by some who for various reasons would not like to see this bill pass, but I will maintain the case in my arguments that it will save dollars.

I think that that is—there is precedent for that and I think it is clear at least to me.

The existing law allows reimbursement only for physicians who may not in many cases have been trained as mental health specialists. The three other core mental health specialists are excluded under present law, clinical psychologists are excluded, clinical social workers and psychiatric nurse specialists are excluded, and that is the cutting edge of the day-to-day working people who actually administer to the needs of those in the mental health field.

Importantly, H.R. 6092 legislatively defines to the Federal level the professional standards and the type of educational requirements necessary for each of the four traditional mental health disciplines. I am confident, therefore, that only highly qualified practitioners will become reimbursable under the law.

I recognize the need for drafting tight legislation and regulations to go with it so that not every Tom, Dick, and Harry who wants to give some advice to someone would qualify for reimbursement.

There is precedent for including these other mental health specialists. The States have been enacting freedom of choice laws making it mandatory for services of other professionals to be reimbursed when similar services are reimbursable to psychiatrists. Private insurance companies increasingly include these other professionals.

Many of the most important Government employees organizations include these mental health specialists. Most importantly, increasing the availability of mental health services by including these other core mental health providers would not result in huge cost increases for the program. In fact, there is every indication that including them would help stabilize escalating health costs and I would go now to how that is possible.

Psychiatrists simply charge more for their services than these other groups. Mental health benefits are cost effective, reducing other health benefit costs. This is demonstrated over and over again by research. It is possible to increase coverage to include other core health specialists without raising overall costs. I have seen no evidence of insurance carriers or industries needing to raise premiums due to the addition of these health providers.

As you know, if they get what is needed at a less expensive session then the reimbursement is less and it reminds me, Mr. Chairman, of the situation we were in for some time until you and others corrected it, and that is that in order to collect any medicare you had to be hospitalized. Therefore, you went to the hospital and collected at a much higher rate. The outpatient proviso which is now working I am sure will ultimately, when the figures come in, demonstrate cost effectiveness.

Use of other health providers would reduce the cost of hospital, medical and surgical costs. Studies by health groups point to reduced medical costs with even short courses of outpatient mental health treatment.

Some of these findings are remarkable. They demonstrate long-term reduction in the use of other medical services with only brief mental health treatment. Mental health benefits costs are stable, predictable and affordable.

The Federal employees health benefit program has been a thoroughly studied program as any health program available, and I would commend to you and your staff and other members of the committee a quick review of that and the decisions and the factors and elements that went into those decisions to include this kind of provision in the Federal employees health benefit program.

Of the total dollar benefits paid out since 1970, the treatment of psychiatric illnesses has remained the same.

Now, I have to be just a little provincial before I close, Mr. Chairman. I represent a congressional district in which a good many of my constituents live a fair distance from hospital facilities, 100 miles from the nearest psychiatrist in some cases, and not only the cost to the medicare program but to the individual, to avail themselves of these services, I think is important.

The existing mental health delivery systems include these four core professional groups. But medicare and medicaid does not recognize the valuable contributions that are made by these core groups, because it only directly reimburses physicians. It is that that I would like to see changed.

Ironically it reimburses the least available, the most expensive, and the smallest group of mental health specialists. We as a nation, I believe, must take advantage of the mental health services provided by clinical psychologists, clinical social workers and psychiatric nurse specialists.

The purpose of this bill, in closing, is to provide the elderly and poor with greater options in health care services and to provide the taxpayers this at less cost.

[The prepared statement follows:]

### STATEMENT OF HON. FLOYD J. FITHIAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

I am very pleased to come before this committee to testify in support of H.R. 6092, a bill to amend titles XVIII and XIX of the Social Security Act to provide more adequate coverage of the services of mental health specialists under the medicare supplemental benefits program and under medicaid programs.

I want to particularly express my appreciation to Congressman Andy Jacobs who as Chairman of the Subcommittee on Health has decided to hold hearings on this important and much needed legislation. Congressman Jacobs and the other distinguished members of the Subcommittee have worked diligently over the years on behalf of the mental health needs of medicare recipients. Because of your interest and concern in this area, I respectfully urge you to support H.R. 6092.

This legislation would insure that qualified mental health specialists would be directly reimbursable under these Social Security programs, without any federal requirement of physician supervision or referral. The purpose of this bill is primarily to offer elderly and low-income beneficiaries greater options in their search for a mental health provider and to save valuable health care dollars.

The existing law allows a medicare or medicaid beneficiary to obtain mental health services only from a physician—who may not have even been trained as a mental health specialist. The three other core mental health specialists are excluded—clinical psychologists, clinical social workers, and psychiatric nurse specialists.

As in so many other areas, the states have demonstrated the leadership in establishing programs that allow a beneficiary to have freedom of choice in selecting his or her mental health specialist. The majority of states now have "freedom of choice" laws for psychologists, and eleven states have enacted similar legislation for social workers. These laws stipulate that where mental health services are reimbursed to psychiatrists, psychologists and clinical social workers must also be reimbursed.

Many private insurance companies have issued policies providing coverage of these mental health specialists. In addition, many of the most important government employees organizations recognize the need to reimburse clinical psychologists, clinical social workers, and psychiatric nurse specialists. For some time the Department of Defense's Champus program has been directly reimbursing clinical psychologists for mental health services, and for the past two years has been reimbursing clinical social workers and psychiatric nurse specialists for their services.

We as a nation must recognize that the mental health delivery system has changed drastically in the last two decades, with states and private insurance companies providing the leadership. Now the time has come for the federal government to recognize the need to make a fundamental change in the social security system by broadening and expanding coverage to include direct reimbursements to all of the mental health specialists.

The 1978 President's Commission on Mental Health recommended that all existing private and public health insurance systems, including medicare, as well as any future national health insurance program, should provide for mental health care in the "most appropriate and least restrictive setting; and the consumer should have a choice of provider and provider systems." Certainly the reimbursement of clinical psychologists, clinical social workers and psychiatric nurse specialists makes available a wider range of therapeutic services. Non-discriminatory coverage of all four core professions would give the elderly and the poor the same freedom of choice which is enjoyed by their fellow Americans. The present system of financial reimbursements clearly works at cross-purposes with other federal efforts to improve the mental health delivery system.

The underserved mental health populations—rural residents, small town dwellers, the urban poor and racial and ethnic minorities—are particularly impacted by the existing system of financial reimbursement for mental health services. As a Congressman from northwestern Indiana—largely small towns and rural areas—I can directly attest to the limited mental health resources in these communities. Many towns are without a doctor, and a psychiatrist is many miles away. Under these circumstances it only makes sense to utilize the other mental health services which are available. Why should a patient seeking mental health services be forced to drive many miles to a distant town simply because it is the only way under the existing law to get reimbursement for these services?

The present system of financial reimbursement for mental health services includes only physicians, who are the least available and the most costly. Although psychiatrists play an important role in the mental health system—since they alone can prescribe medication—they treat only a small portion of patients. The time has come to recognize those mental health specialists that provide the bulk of the services and establish a system that allows them to be directly reimbursed for their services.

Importantly, H.R. 6092 legislatively defines at the federal level the professional standards and the type of educational requirements that are necessary for each of the four traditional mental health disciplines under which they can practice independently. I have specifically spelled out the proposed definitions of clinical psychologists, clinical social workers, psychiatric nurse specialists, and psychiatrists. By adopting these strict educational requirements, as well as state licensure and/or certification, I am confident that only highly qualified practitioners will become reimbursable under the law.

Again, many of the states and professional organizations have taken the lead in establishing licensing and certification laws, as well as minimum requirements for education and experience. Psychologists, for example, are subject to licensing in fifty states and the District of Columbia. Clinical social workers are subject to licensing in twenty-six states, containing the majority of the nation's population. The professional organizations are demonstrating continued commitment to stringent minimum standards of practice. Where licensing is not dictated by state law, the organizations are working in support of the passage of laws to help enforce the highest possible standards.

Most importantly, increasing the availability of mental health services to our nation's social security recipients by including clinical psychologists, clinical social workers, and psychiatric nurse specialists will not result in huge cost increases for the program. In fact, there is every indication that including these providers would help to stabilize health costs. How is this possible in an age of rapidly escalating prices and inflationary pressures? First, psychiatrists simply charge more for their services than the other mental health specialists. Every statistic I have seen points to the fact that physicians charge the highest cost per unit of therapy of any of the mental health professionals. Further, median fees vary widely among the professions. It doesn't make sense to me to restrict medicare and medicaid patients to the services of one profession, especially the one that charges the highest rates. Inclusion of non-physician providers allows an opportunity for the positive fiscal consequences of competition. The Federal Trade Commission cites studies indicating mental health costs under national health insurance would be increased by 63 percent if only psychiatrists were included as providers. The cost would increase by only 11 percent if both psychiatrists and psychologists were included. Although clinical social workers and psychiatric nurse specialists were not studied, one could conclude from the data that inclusion of these provider groups would also contribute to decreasing mental health costs.

Second, mental health benefits are cost effective, reducing other health benefit costs. Studies by governmental agencies as well as the private sector industry consistently demonstrate that patients who receive short-term out-patient psychotherapy reduce their usage of other medical services. This data is not shocking news. General practice physicians have long been aware of the high percentage of patients who are suffering physical symptoms; for example, spastic colon, and migraine headaches, caused by underlying nervous and mental disorders. A study conducted by the Group Health Association of Washington, D.C. found that patients who received short-term out-patient psychotherapy reduced their usage of general medical services and of x-ray and laboratory services by 30.7 percent. An analysis of the impact of mental health counseling on medical care utilization sponsored by NIMH indicated that there was a reduction of medical utilization ranging from 5 to 85 percent. This reduction of medical utilization was found in 21 out of 22 studies. Kaiser-Permanente, in another study of mental health benefits done over a 16-year period, concluded that patients who underwent short-term psychotherapy showed a reduction of almost 75 percent in medical utilization over a 5-year period. Data collected over many years from the Kaiser-Permanente health insurance plan demonstrated that only one to four sessions of psychotherapy returned an average of 2.59 dollars of every dollar invested in therapy. Several other comprehensive and lengthy research studies conducted in group health insurance plans suggest that an average of fewer than 9 sessions of outpatient mental health therapy reduced use of medical services by 75 percent. Consequently, it is possible to decrease physical health services which have become exceedingly costly.

Third, it is possible to increase coverage to include other core mental health specialists without raising overall costs. I have seen no evidence of insurance carriers or industries needing to raise premiums due to the addition of these health providers. The New York State Department of Insurance has provided information typical of the statistics available. A review done by the department indicated no additional costs when insurance carriers added clinical social workers as providers. According to the report not one company has raised its rates for social work coverage since the initial submission of such coverage in 1978.

Fourth, the use of other core mental health providers would reduce the cost of hospital, medical, and surgical costs while stimulating worker productivity. A pilot program conducted at a Kennecott Copper plant in Salt Lake City, Utah, showed the cost-effectiveness of an on-site, outpatient mental health program. Over a 1-year period, the employees involved showed a significant reduction in absenteeism—from 5.8 working days per month to 2.93 days, a drop of 40.5 percent—and in-hospital, medical, and surgical costs—from $109.04 per person per month to $56.91 per person per month, a reduction of 48.7 percent. Over the same period the control group—those not involved in the outpatient mental health program—showed a 2 percent increase in absenteeism and a 7.7 percent increase in hospital, medical, and surgical costs. Consequently, we as a nation can actually reduce the overall costs of our health programs while expanding the scope of mental health services and fully utilizing other core mental health specialists.

Fifth, mental health benefit costs are stable, predictable and affordable. The Federal Employee Health Benefit program has been as thoroughly studied as any health program available. Of the total dollar benefits paid out in FEP, the treatment of psychiatric illness accounts for about 7 percent of all health benefits paid since 1970. The percentage has remained stable and consistent.

The existing mental health delivery system includes four core professional groups, but medicare and medicaid does not recognize these contributions because it only directly reimburses physicians. Ironically, it reimburses the least available, the most expensive, and the smallest group of mental health specialists. We as a nation must take advantage of the mental health services provided by clinical social workers, clinical psychologists, and psychiatric nurse specialists. We cannot continue to neglect these fundamental human resources within our communities across the country. The time has come to directly reimburse these other mental health specialists for their services under medicare and medicaid.

For much too long, mental health programs in general have been relegated to second-class status and the contributions of clinical social workers, clinical psychologists, and psychiatric nurse specialists have been ignored and forgotten. The general public has not known or understood the complex mental and emotional problems experienced by millions of Americans nor appreciated the services provided by mental health specialists.

We must now remove these inequities in the law by amending the existing medicare and medicaid programs. I respectfully urge my colleagues to support H.R. 6092.

Chairman JACOBS. You said there is evidence from private carriers who have extended this coverage, that the premiums have not increased as a consequence of the extension of this.

Do you have specifics?

Mr. **Fithian**. We have that in the full text of the statement. I have spared the committee for the many witnesses they have this morning, reading the entire text.

Chairman **Jacobs**. Counsel, do you have questions?

If not, we are in your debt. You are the one that started the ball rolling. As I say, your testimony will undoubtedly keep this going for some time. The stitch in time, and all that, is obscure.

I recall at the beginning of this Congress the new administration called for repeal of anything that was passed in the previous year; and one of the things passed in the previous year was precisely what you referred to a moment ago, freestanding clinics and direct reimbursement and so on. In time I think it is fair to say that the administration changed its mind about such a sweeping analysis.

It is true that progress doesn't necessarily mean improvement, but in this case it is clearly not retrogression either. I commend you for that work.

Mr. **Fithian**. Mr. Chairman, thank you again for allowing me to testify and I would say that I am sure that in due course you will have brought upon the committee rather considerable pressure from certain segments of the health care industry, such as the American Medical Association, because it is to their dollar and cents benefit to keep that reimbursable to only doctors rather than to those who may otherwise see these individuals.

But I trust that the greater good can prevail here in terms of the individuals in need of this care.

Thank you again.

Chairman **Jacobs**. Thank you, I thank you for your contribution.

Dr. Don Young, Deputy Director of the Bureau of Program Policy for the Health Care Financing Administration.

## STATEMENT OF DONALD A. YOUNG, M.D., DEPUTY DIRECTOR, BUREAU OF PROGRAM POLICY, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMEMT OF HEALTH AND HUMAN SERVICES

Chairman **Jacobs**. You know the rules of the New York State Athletic Commission or whatever, so proceed in your fashion.

Dr. **Young**. Thank you.

I am Donald A. Young, Deputy Director, Bureau of Program Policy for the Health Care Financing Administration [HCFA]. I am pleased to be here to discuss two bills—H.R. 3921, which would expand the medicare program to provide coverage of personal emergency response services, and H.R. 6092, which would expand medicare and medicaid coverage of services furnished by mental health specialists.

H.R. 3921 would amend the medicare program to provide coverage of personal emergency response services. The personal emergency response service refers to the provision and periodic maintenance of digital electronic communication equipment in the home of individuals who are functionally impaired and live alone. This device signals a personal emergency monitoring agency for help, over existing telephone lines, when activated by the individual.

The personal emergency monitoring agency is located in the individual's community and provides these emergency response services as an incidental part of the health and social services it provides. The agency would be required to meet performance standards set by the Secretary to assure the reliability of services provided in an emergency situation. There would be a continuous monitoring of signals to determine any false alarms. The emergency monitoring agency would receive provider status under medicare.

The Secretary would establish a reasonable ceiling on the incurred expenses of the monitoring agency. This ceiling may be adjusted from time to time to reflect changes in the general economy and may vary to reflect differences in costs in different geographic areas.

A clinical social worker or other qualified personnel could certify and recertify the need for the services.

We understand the interest in providing personal emergency response services to the handicapped or elderly who have an emergency with no one around to help them. However, coverage of such services under medicare would mean a change in the basic nature of the program. In addition, a 4-year study of such systems by the Department indicates that they would be a cost-effective measure for only a small part of the disabled and elderly population.

As you know, prior to the enactment of the medicare law, there was considerable discussion about the possibility of having the program cover essentially all the costs of necessary health care. The Congress decided that the primary coverage under the program should be for medical services for people who have an acute illness or injury, that is, hospital and related care, physicians' services and certain other medically necessary items and services.

Items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member were specifically excluded from medicare coverage. Since an emergency response system is basically a telephone protective service, it falls within the scope of this exclusion.

An emergency response system is but one component of the type of services provided to elderly and disabled patients commonly called long-term care. Long-term care services typically include traditional nursing home services or, as an alternative, day or home care services which help functionally impaired people stay in their homes. While long-term care services are covered under medicare only for people needing skilled care, needy individuals are authorized these services under the medicaid program.

We recognize the need to address the issue of the type and diversity of long-term care services available for a steadily growing elderly population. However, with regard to the best ways of providing these services, there remain a number of unanswered questions. One of the main problems with expanding Federal support for long-term care services is the concern that providing these services through a Federal or joint State-Federal program could have the undesirable effect of displacing the very valuable informal support services provided by family and friends to the elderly and disabled.

Chairman **Jacobs**. Would you suspend for a moment.

[Discussion off the record.]

Chairman **Jacobs**. Go ahead, Doctor.

Dr. **Young**. Another concern is piecemeal benefit expansions to the medicare program that ignore an integrated approach to long-term-care policy development. We must, therefore, carefully examine proposals that would expand medicare coverage of long-term-care services.

From 1975 to 1979, HCFA's Office of Research, Demonstrations, and Statistics provided assistance to the National Center for Health Services Research [NCHSR] in the testing of an automated alarm and response system. The demonstration measured the effects of an automated emergency alarm and response system on the psychological and social well-being of aged persons at risk.

The components in the study included: (1) Digital electronic communication equipment in the home which automatically signals for help over existing telephone lines; (2) an emergency central station which offers 24-hour, 7-day-a-week service and is responsible for receiving the incoming alarms, identifying the client, screening out accidental—false—alarms, and sending help when required; and (3) emergency response organizations, such as police or visiting nurses and/or individuals chosen by the user, who have agreed to respond to specific calls for help.

Persons participating in this project were defined as severely or multiple-physically handicapped or clinically judged to be physically vulnerable and/or socially isolated.

The study findings showed:

That the system used in the project reduced the use of nursing homes for certain clients who were severely functionally impaired but did not reduce admissions and length of stay in hospitals;

That the use of home health homemaker services were reduced but not significantly;

That the individuals who need an emergency communication service also need formal and informal community support services to remain at home; and

That the proportion of the handicapped and/or elderly population for whom the system was cost-effective was relatively small.

Because the NCHSR results seem to indicate that only a relatively select group of elderly benefit from emergency alarm systems, we believe that any further demonstration of such systems should be combined with projects testing alternative community services and having the ability to identify patient needs.

Several of the current Office of Demonstrations and Evaluation long-term care "channeling" demonstrations are testing alternatives and have patient assessment and case management components.

Our preliminary estimates are that covering such a service would cost the medicare program over $100 million in the first full year.

Emergency response services are no doubt useful and helpful devices. Indeed, a case could be made for having one in every home programed to call the police, the fire station, the ambulance, et cetera, in case of a true emergency. On the other hand, we doubt that there are many cases in which the emergency response services alone will keep an aged patient at home and out of an institution when the patient's level of care requirements change.

Therefore, we are opposed to the enactment of H.R. 3921. To cover these services would be inconsistent with the background of the medicare program and most importantly would add costs to the program in a time when our efforts need to be focused upon insuring the solvency of the medicare trust funds so that protection will be available for future generations as well as this one.

I would like to move on now to discuss H.R. 6092. H.R. 6092 would amend the medicare and medicaid programs to provide direct coverage of the services of mental health specialists, including clinical social workers, clinical psychologists, and psychiatric nurse specialists. The mental health professionals would be reimbursed directly under these programs without the existing Federal requirement for physician supervision or referral.

Current medicare law does not generally authorize direct payment to clinical psychologists, clinical social workers, and psychiatric nurse specialists. However, psychiatrists can, in their capacity as physicians, bill the program directly and receive payment for their services. In addition, the diagnostic services performed by a psychologist practicing independently of an approved hospital, skilled nursing facility, or physician's office may be covered under medicare as "other diagnostic tests" when performed in accordance with the written order of a physician. Thus, an independently practicing clinical psychologist can bill the program directly for his/her diagnostic services and receive payment on a reasonable charge basis.

The services of the other mental health specialists identified in the bill may be covered under part B of the program if they are furnished "incident to" a physician's professional service and are furnished in a physician's office, physician-directed clinic, mental health clinic, or hospital outpatient department.

In the case of the latter services, they must be furnished under the direct personal supervision of a physician and they must be billed for either through the physician, clinic, or hospital involved.

Medicaid also covers physician services. In addition, States have the option to cover medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of practice defined by the State law. These services could be furnished by clinical social workers, clinical psychologists, and psychiatric nurses. However, the services furnished in a clinic must be "physician directed." We are not clear as to the intended effect of the proposed amendments to medicaid provisions of the law.

Presently, there is an interagency effort by HCFA, the Public Health Service [PHS], and the Office of the Secretary to assess the impact and benefits of cost-related medicare reimbursement to freestanding outpatient mental health facilities.

Forty facilities are participating in the demonstration which consists of: 14 community health centers, 12 ambulatory mental health centers, and 14 partial hospitalization facilities. Reimbursement for services to medicare beneficiaries extends from April 1981 through April 1983. Both the range of services and type of provider will be expanded under the demonstration, and reimbursement will be on a cost—not fee-for-service—basis to the facility.

Under this demonstration, all services must be provided by a qualified mental health professional [QMHP] who meets the demonstration qualification requirements for a psychiatrist, psychiatric social worker, psychologist, or psychiatric nurse.

The demonstration is designed to:

Determine the effects on medicare part B utilization and costs of services of providing medicare reimbursement to freestanding community-based facilities providing mental health services;

Determine the effects on medicare part B utilization and costs of services of providing medicare reimbursement for services delivered or supervised by a qualified mental health professional in the community-based facility setting; and

Determine if medicare reimbursement to community-based mental health facilities increases use of the services by medicare eligibles.

Since the demonstration will end April 14, 1983, preparations are being made to facilitate a smooth phaseout process. This will include notification to all beneficiaries whose services may be affected and an offer of assistance by the facility for referral to any other treatment source or financial aid in meeting expenses no longer reimbursable by medicare.

The evaluators are collecting data and making final selection of comparison facilities. The final evaluation report is due in December 1983.

Also, the Omnibus Reconciliation Act of 1980, Public Law 96–499, mandates the Secretary to conduct a demonstration which would determine the effects of making the services of clinical social workers more generally available under medicare. A demonstration project is now being planned which will look at the administrative, financial, and other aspects of recognizing clinical social workers as independent practitioners who can be directly reimbursed.

The demonstration will allow, on a statewide basis, direct reimbursement to clinical social workers for their services rather than reimbursement through a physician or clinic. There will be no requirement for physician referral.

Studies indicate that in many cases patients age 65 and over, with psychiatric symptoms, have problems that are either directly related to or actually caused by physical conditions. In addition, it is estimated that a very high percentage of the elderly have chronic health conditions which may directly affect their mental and emotional condition as well as their responsiveness to treatment.

One problem with changing the law to permit direct reimbursement for services furnished by nonphysician mental health specialists is that such a change would provide no assurance of direct patient assessment by a physician. Assessment by trained physicians as well as psychologists is of particular importance in determining the most appropriate mode of treatment for elderly persons who show symptoms of mental illness.

In addition to mental health specialists, many other categories of nonphysician practitioners have indicated an interest in direct medicare reimbursement. Thus, any proposal to expand direct reimbursement authority to include mental health specialists would also raise the question of whether they should be treated differently from other nonphysician practitioners who wish to bill medicare directly.

As with H.R. 3921, we believe that HCFA has insufficient evidence at this time to justify changing current statutory quality assurance safeguards for physician direction of physical and mental health care provided to medicare beneficiaries.

We are optimistic that the present demonstration project regarding community clinical social workers will provide us some answers to our concerns. In the meantime, we oppose the passage of H.R. 6092.

Mr. Chairman, this concludes my statement. I would be happy to answer any other questions you may have.

Chairman JACOBS. Thank you.

Ms. Jost will inquire of emergency response.

Ms. JOST. In your statement you have said that the first 4-year cost of H.R. 3921 will be $100 billion. Can you tell us more about your assumptions in that estimate?

Dr. YOUNG. In preparing our assumptions on that estimate, the user population we project was that portion of the population using home health services and that portion estimated to be living alone using those benefits.

We further used an estimated monthly rental charge of $20 in 1982 in constructing estimates.

The estimate assumes that the equipment is rented rather than purchased, and it assumes it will include nominal installation costs. We also assumed that supply will be more than exceed demand initially, but demand will grow to meet supply by the fifth year of enactment.

Ms. JOST. You state also in your testimony that you are opposed to the emergency response system as a piecemeal approach to the long-term care.

Dr. YOUNG. Yes.

Ms. JOST. Are you working on a more comprehensive long-term care policy or proposal in the administration at this time?

Dr. YOUNG. The issues related to long-term care have been under discussion off and on for a number of years, and continue to be of importance to us, ranging from nursing home services to home health care services, to community services.

One of the major purposes of the channelling demonstration is an attempt to understand more about how a full package of comprehensive services can be obtained. There is a great deal of work going on in the area of long-term care in attempting to provide an appropriate package of services.

Ms. JOST. The study you sponsored, the National Center for Health Services Research, indicated that severely functionally disabled and not socially isolated individuals who use these services experienced a significantly lower incidence of nursing home care.

Given the fact that medicaid now finances nearly half the Nation's nursing home bill, has HCFA considered whether medicaid coverage of personal emergency response services for the functionally impaired will be an option to this?

Dr. YOUNG. Personal emergency response services are currently covered in the medicaid program in a number of States. They are covered as part of the home and community-based waivers with respect to section 1915(b). As part of the requirement we ask the States to assure us that the services will be cost-effective, and several States have given such assurances.

Ms. **Jost**. We have a couple more questions for the record.

Dr. **Young**. Thank you.

Chairman **Jacobs**. They will be submitted in writing if you would respond.

[The information follows:]

COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
*Washington, D.C., December 16, 1982.*

Dr. DONALD A. YOUNG,
*Deputy Director, Bureau of Program Policy, Health Care Financing Administration, Washington, D.C.*

DEAR DR. YOUNG: Thank you for testifying before the Subcommittee on Health on December 14, 1982. As I mentioned in the hearing, additional questions have been prepared which we would like answered for the record. The record will remain open until January 31, 1982.

Please provide a detailed analysis of the cost estimate that the Department made for H.R. 3921 and H.R. 6092. In addition, regarding personal emergency response systems:

1. Do you think there would be any cost savings to the medicare program if H.R. 3921 was targeted to the severely functionally impaired but not socially isolated individuals?
2. Do you think the Department would be able to identify this group of severely functionally disabled but not socially isolated individuals, if the medicare benefit was written to cover this group only?
3. Do you think that the study, funded by the National Center for Health Services Research provided useful information for purposes of discussing medicare coverage of personal emergency response systems?
4. The Committee would be interested in learning more specifics about the Community Care Waiver's Act that have been provided under the medicaid program for personal emergency response systems. What assurances were made that these systems would be cost-effective?

Sincerely,

ANDY JACOBS, Jr.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

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WAYS AND MEANS
HEALTH SUBCOMMITTEE

The Honorable Andy Jacobs, Jr.
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Jacobs:

I am responding to your letter of December 16, 1982 in which you requested additional information for the record in connection with the hearing on H.R. 3921 and H.R. 6092.

Attached are HCFA's cost estimates on H.R. 3921 and H.R. 6092 and our answers to your questions.

If I may be of further assistance, please let me know.

Sincerely,

Don Young

Donald A. Young, M.D.
Deputy Director
Bureau of Eligibility,
Reimbursement, and Coverage

Attachments

## Medicare Cost Estimate and Assumptions for H.R. 3921-- Medicare Coverage of Personal Emergency Response Services

### Description

This bill will cover Personal Emergency Response Systems (PERS) for "severely functionally disabled" persons living along or likely to be alone for a substantial amount of time.

Provision of equipment and maintenance will be covered, subject to the usual part B copayments (20 percent coinsurance, $75 deductible). The Secretary will determine a reasonable ceiling for incurred charges.

Qualified personnel, other than physicians, can certify the need for such equipment.

The legislation will be effective 60 days after enactment. For purposes of this estimate, it has been assumed that the bill be passed 1/83; effective 3/1/83.

### Assumptions

1. User Population

The user population is that portion of the population using home health services which is estimated to be living alone.

2. Monthly Rental Charge

The monthly rental charge is estimated to be $20.00 in 1982. This amount will increase with the projected increases in the economic index. From the available data, it is unclear as to whether this $20 covers the initial investment in equipment. Based on discussions with Lifeline, Inc., these estimates assume that the $20 includes the recovery of equipment costs along with the cost of monitoring, servicing, staff, and overhead.

This monthly charge is based on data from a major manufacturer of PERS equipment. Since it is in their self-interest to promote Medicare coverage, their information may be biased on the low side.

This estimate assumes that the equipment is rented. If the equipment is purchased, then the cost estimates will change substantially. The population would be smaller as the cost per user would be greater.

3. Installation Charges

Since installation charges vary from $6.00 to $50.00 depending on whether there are one or more phones in the house, these estimates use a $30.00 installation charge. This is the only charge other than the monthly rental.

4. Supply

Supply is assumed to meet demand by the fifth year after enactment.

5. Certification as Medicare Provider

No new provider status will be granted. We have assumed that the regulations will be written such that personal emergency response services will be an extremely small percentage of the established services of a provider. If new Medicare providers are certified mainly to service personal emergency response systems, then the cost will be significantly greater.

6. Additional Costs or Savings

We have assumed that there will be no savings accruing to the Medicare program from the passage of this bill.

We have not quantified any additional costs due to the potential increase in use of medical services created by this proposal.

7. Other

This estimate has been calculated independently of any other proposed changes.

Costs Estimate - Effective 3/1/83

| Fiscal Year | Cost to Medicare Program ($ in millions) |
|---|---|
| 1983 | $ 40 |
| 1984 | 105 |
| 1985 | 130 |
| 1986 | 165 |
| 1987 | 200 |

Prepared by:
HCFA, Bureau of Data Management and Strategy
Division of Medicare Cost Estimates

## Medicare Cost Estimate and Assumptions for H.R. 6092--Coverage of Mental Health Specialists

### Description

This bill will provide for the direct coverage of the services of clinical psychologists, clinical social workers, and psychiatric nurse specialists without the present requirement for physician supervision or referral.

The existing $500 ceiling on charges for mental health services and the additional limit of 62.5 percent applied to such services will be maintained. The usual part B coinsurance and deductible will apply. It is important to make clear that the reimbursement limit of $250 applies to the total of all mental health services used by any individual.

The bill will be effective in the first full calendar year after passage. Hence, we assumed an effective date of 1/1/84.

### Assumptions

1. Supply

   We have analyzed the number of full time equivalent mental health practitioners available. Based on this work, we have estimated that this additional group will increase the current level of reimbursement for mental health services (i.e., psychiatrists) by 150 percent.

   Since there is a limit on total reimbursement per person ($250.00), it is very difficult to estimate how an increase in practitioners will translate into an increase in costs. We feel that this estimate is realistic based on the fact that persons currently using services may use more services plus the fact that there may be many new users.

   The additional mental health specialists will now be able to bill independently and will likely take advantage of this opportunity.

2. Demand

   Demand will meet available supply by the third year after enactment.

3. Other

   This estimate has been calculated independently of any other proposed changes.

Cost Estimates - Effective 1/1/84

| Fiscal Year | Cost to Medicare Program ($ in millions) |
|---|---|
| 1983 | $ 0 |
| 1984 | 20 |
| 1985 | 55 |
| 1986 | 80 |
| 1987 | 95 |
| 1988 | 115 |

The financial impact of this provision on the Medicaid program is likely to be negligible, since the services of mental health specialists could be covered at the State's option under other provisions of the law.

Prepared by:
HCFA, Bureau of Data Management and Strategy
Division of Medicare Cost Estimates

## QUESTIONS AND ANSWERS REGARDING PERSONAL EMERGENCY RESPONSE SYSTEMS

1. Q. Do you think there would be any cost savings to the Medicare program if H.R. 3921 was targeted to the severely functionally impaired but not socially isolated individuals?

   A. As we understand the question, you want to know the impact on the costs of removing the qualification that the recipients be "socially isolated." There are more people who are "severely functionally impaired" than people who are not only severely functionally impaired but also socially isolated. Changing the target population to the group of beneficiaries who are severely functionally impaired would create a larger target population and hence lead to an increase in Medicare covered demand. Therefore, the effect of such a change would be to increase Medicare costs.

2. Q. Do you think the Department would be able to identify this group of severely functionally disabled but not socially isolated individuals, if the Medicare benefit was written to cover this group only?

A. The National Center for Health Services Research (NCHSR) project developed special definitions of its service population for study purposes, based on functional categories set up in advance or refined as a part of the research design, and was able to identify this group for the purpose. However, the Department could not currently identify this group. In order to do so, we would have to collect additional information from beneficiaries, carriers, and providers. This would be burdensome and costly and not necessarily guarantee positive results.

3. Q. Do you think that the study, funded by the National Center for Health Services Research, provided useful information for purposes of discussing Medicare coverage of personal emergency response systems?

A. Yes, the National Center for Health Services Research study does provide useful information for purposes of discussing Medicare coverage of personal emergency response systems.

The primary objective of the study was to evaluate the impact of an automatic emergency alarm and response system known as "Lifeline" on the well being (including the prevention of institutionalization) of elderly persons designated as potentially requiring this type of system. Three groups of individuals received the Lifeline system:

- Severely functionally impaired and socially isolated;
- Severely functionally impaired but not socially isolated; and
- Socially isolated and either moderately functionally impaired or medically vulnerable.

Since this was a Public Health Service project, the study participants did not have to be on Medicare or Medicaid. However, the vast majority were eligible for both programs. Of the three groups, only one, those who were severely functionally impaired but not socially isolated, demonstrated the potential for cost savings, but not in the area of Medicare services. These savings accrued as a result of a reduction in the average nursing home length of stay and the number of home health aide/homemaker visits. This nursing home care was not the nursing and rehabilitation intense services covered by Medicare, but more similar to the chronic nursing and/or personal care services covered by Medicaid. The home health aide/homemaker visits were not usually the type accompanied by a Medicare qualifying skilled service, but were the type used for maintaining chronically disabled individuals. The number of acute hospital days was not significantly different for individuals in any of the three treatment groups versus their 2 of 4 control group counterparts. Similar results (no significant difference between groups) were obtained when the study assessed the value of ambulance, outpatient emergency room visits and physician utilization which are commonly covered Medicare services.

4. Q. The committee would be interested in learning more specifics about the Community Care Waiver's Act (sic) that have been provided under the Medicaid program for personal emergency systems. What assurances were made that these systems would be cost-effective?

A. To date, New York and Colorado have approved 1915(c) waivers that include electronic emergency systems.

Although section 1915(c) of the Social Security Act does not specifically identify personal emergency response systems as a service under the home and community-based services waiver program, States may be granted approval to provide such a system only if they demonstrate to HCFA's satisfaction that the services:

- Are cost effective;

- Are necessary to avoid institutionalization; and

- Are clearly defined.

States must specifically demonstrate the cost effectiveness of these services, in addition to including them in the State's estimated average per capita expenditures under the waiver (which may not exceed the average per capita expenditures which would be made if these individuals were institutionalized).

New York indicated the cost-effectiveness of its emergency alarm response system by stating that patients would be more secure in leaving SNFs and ICFs if they had these emergency systems and they would effectively reduce the need for costly on-site supervision. The device, New York stated, not only assisted individuals to avoid institutionalization but also allayed the fears of those being deinstitutionalized. The State indicated that no one would be offered home and community-based services if the costs of all such services an individual requires are determined to be more than 75 percent of the cost of institutional care for that individual.

Colorado's personal emergency system was likewise identified in their waiver request as a necessary system to assist individuals to avoid institutionalization and its annual cost, together with the annual cost of all other home and community-based services the State proposes to offer, was clearly less costly than institional care.

Chairman **Jacobs**. Concerning reimbursement of other health care providers, Ms. Casber will inquire.

Ms. **Casber**. Dr. Young, we have a preliminary cost estimate on H.R. 6092, mental health legislation, from the CBO, Congressional Budget Office, which shows the first year cost of between $5 million and $20 million. This takes into account the 50-percent coinsurance which currently applies to outpatient mental health services, and the current $250 limitation.

Has HCFA done any cost analysis of that legislation?

Dr. **Young**. Yes. Our preliminary analysis of that legislation indicates in the first full year of implementation the cost to the medicare program will be $20 million, as I understand, which is at the upper limit of the CBO estimate.

Ms. **Casber**. What about future years?

Dr. **Young**. In the second year, $55 million; third year, $80 million; fourth year, $95 million; fifth year, $115 million.

Ms. **Casber**. Could you provide us with the cost estimates in written form?

Dr. **Young**. Yes.

Ms. **Casber**. A number of studies have shown the use of mental health services significantly reduces the use of other medical services. Has HCFA done an analysis of that? Or wouldn't that have the potential of saving the medicare program some money?

Dr. **Young**. Yes. Again, the mental health demonstration underway now will look not only at use and demand of these services, but the impact of those services on the full array of services that individuals use.

Ms. **Casber**. You have not mentioned the Colorado study done with respect to the use of clinical psychologists under medicare. Could you briefly describe that.

Dr. **Young**. The Colorado study did not have a good patient intake or good participation from providers.

The data from that study, therefore, is difficult to generalize and from a statistical point of view it is hard to justify the findings. The findings were that there was minimal increase in cost per beneficiary, but because of the low intake population and low number of providers available, we cannot generalize further.

Ms. **Casber**. I take it the clinical social worker study will make efforts to eliminate some of the flaws in the earlier one?

Dr. **Young**. Yes; very much so. In fact, one of the things we are stressing in that study is a campaign, if you would, to notify providers and beneficiaries of the availability of the study so we will not have that intake problem.

Ms. **Casber**. Thank you.

Chairman **Jacobs**. Dr. Young, is this administration still preparing proposals concerning competition in the health care field?

Dr. **Young**. Yes, sir.

Chairman **Jacobs**. How do you relate the proposal to reimburse other mental health care providers directly with the idea of competition?

Dr. **Young**. I think the proposal has several parts that have to be examined. One part is an expansion of a significant number of potential people who can provide services, the second is the question of whether they bill direct or are paid on a cost basis, and the third is the nature of the services provided.

The outpatient mental health benefits in the medicare program have tended to deal with patients who have mental problems of a significant magnitude. However, mental health services can be defined broadly to include social and supportive services as well.

When you address the question of competition, will the clinical social workers and others be providing the same nature and type of services, or will they be providing an add-on service? Our concern is that it will be an add-on service and our concern is with the cost estimates related to it.

Our concern does not relate to competition.

Second, the question of direct billing and direct reimbursement raises the level of the fees to be paid under direct reimbursement, and will those fees be similar or will they be at different levels? The answer is not known, of course, to that question.

Chairman JACOBS. Well, how about just giving us a couple examples where there would be competition of mental health care providers in the first instance, medical doctors; second, nurse practitioners or individuals who have not heretofore been treating with the primary regard that medical doctors have been.

It is apparent to me if there is such a possibility there is no possibility for competition as far as physician care is concerned.

Dr. YOUNG. That is correct. If both practitioners were delivering an identical or related service, then the beneficiary would have the option of looking at such things as the fee charged, closeness to home, access, and personal preferences to instill a degree of competition into the system.

Flowing from that is the issue I raised on reasonable charge. Would it instill price competition as well as competition for access and for services to be provided? That would depend on the level of the charge set and whether price competition was there.

Our concern is not in dealing with the issue of competition—that is, whether providing the same or similar services is involved—but, rather, the displacement of support services now provided by friends, family, church, and other sources.

Under H.R. 6092, these services may be provided by a group of providers billing the program directly for what would not be provided currently by psychiatrists.

Chairman JACOBS. In the case of psychiatric nursing services provided through the auspices of the psychiatrist's office now, I assume that the psychiatrist is not going to hurt himself or herself in billing for that. That is just an assumption.

I wouldn't want you to not take that into account. Would the direct reimbursement work if it was policed properly so it didn't take the place of Aunt Betty's best advice or Mary Worth?

Dr. YOUNG. If the psychiatrist saw the patient, I would assume the relationship would be the same as if there were a referral. There would be good communication and an appropriate level of referral.

Under the bill, however, the psychiatrist would not necessarily be involved in any form of referral. There would not be a relationship between practitioners, although there could be.

Chairman **Jacobs**. Well, for years the bar association where I come from used to be quite exorcised because realtors would write a sales contract on land. With all due respect, I would have to say that the general practice, at least where I practiced law in my office, was that a very good paralegal in the office knew 10 times as much about that particular contract as any lawyer, and probably almost as much as the realtors knew about drawing up that particular contract.

I have always wondered if there isn't room for the highly trained persons without being skittish about elements of service that can adequately be provided by a person who has not been trained, say, for quite so long a time in school.

That is why I hope the administration, all people of reason, would be looking toward that. I don't think there is any question but that someone else can provide exactly the same service in that instance as the person who can also provide a higher level, call it that, of service. There is going to be price competition in that sense. It is inevitable.

Detroit knows that.

I just would hope that the administration would not have a completely blind side. I don't have a blind eye myself to the administration's arguments. I think they are well stated and not illogical, if not always applicable.

So I just hope the administration will remain objective about this. I should think that probably in the new Congress this subcommittee would be interested in exploring the matter further, perhaps even informally with the administration subsequently.

I am sure that you will agree that the administration ought to be exposed with an open mind here.

Dr. **Young**. Yes, sir.

Chairman **Jacobs**. Thank you, we are grateful for your testimony.

Dr. **Young**. Thank you.

Chairman **Jacobs**. The Chair will announce two things.

First of all, we have what to the naked eye looks like an interminable witness list. Conciseness is considered attractive here. As a matter of fact I almost forgot, I give a $1 first prize to the person who testifies the most briefly. Quality is not necessarily judged, I am not competent to do that. And a Kennedy-half to the person who comes in second.

Anybody interested in that competition, let's proceed.

Our next witness is Dr. John Morris, department of social gerontological research, Hebrew Rehabilitation Center for the Aged, Boston, Mass.

## STATEMENT OF JOHN MORRIS, PH. D., DEPARTMENT OF SOCIAL GERONTOLOGICAL RESEARCH, HEBREW REHABILITATION CENTER FOR THE AGED, BOSTON, MASS.

Dr. **Morris**. Thank you.

The department of social gerontological research at the Hebrew Rehabilitation Center for the Aged, of which I am associate director, was responsbile for carrying out the NCHSR funded study of personal emergency alarm services.

I am going to comment on some key findings from that study that are germane to the decision in this legislation.

I am also going to comment on some of the other emergency alarm systems that exist across the country and in Europe.

In our study which followed several hundred people for 14 months, individuals who were functionally impaired living alone and not socially isolated were found to experience significant quality of life cost savings as a result of using this service. Functionally impaired people included those restricted in one or more activities of daily living. Isolation was defined as having or not having daily contact and monitoring by others.

For the group of individuals who were impaired, lived alone and not isolated, there were reductions in anxiety. Persons more satisfied with their living conditions and general life. They also had less trouble sleeping.

There was a lower utilization of long-term care institutional days.

With respect to cost, for every dollar of cost involved in providing services to these people, based on 1979 dollars, there was a $7.19 savings.

The intervention itself is relatively inexpensive, and the per month cost savings in 1979 dollars amounted to $114.

Thus, one of the keys to success in any application of a system like this is to target to these types of people.

Who are these people? What proportion of the population might they represent?

In a survey we did in the State of Massachusetts this past year of some 4,000 elderly persons identified on a random basis, we would estimate that about 20 percent of the population is vulnerable. About 8 percent are vulnerable and live alone.

About 6 percent are vulnerable, live alone, and are not isolated.

Thus, 6 percent is a reasonable estimate of the total number of people who might be subject to this system.

Other keys to the success of this intervention from our perspective included the ceiling on the reimbursement. As I said, the intervention was relatively inexpensive. That was considered a crucial factor.

Second, prevention—the implementation of an intervention that precluded agencies from using the service as a case-finding mechanism.

This was not a mechanism that the existing health care system utilized to fill the vacant acute hospital beds.

This was not used by VNA's to bring cases into their system. The system was utilized as an emergency response system only.

People were brought in and help was sent out only when required on the basis of a careful monitoring of information provided by the vulnerable person over the telephone.

We considered those three components as crucial.

Serve the right people, have a ceiling on reimbursement, guaranteeing the integrity of the response system itself.

At the time the NCHSR study was funded, there were about two or three alternative systems of this type in the United States. Manufacturers, that is.

At the present time, the system we evaluated is the largest provider of these systems in the United States, Lifeline Systems.

There are many companies in the field, however.

To acquaint local AAA agencies concerning results of our study, and the availability of potential providers, AOA in 1981 sent memos to all local AAA's in which they identified 15 companies as manufacturers of personal emergency response systems.

The systems fall into one of three basic models, one, a community-based medical model, located, for example, in a health agency, having responsibility for monitoring persons in a specific geographic area with integration into the local health and social service system for the necessary emergency response component.

That was like the model we evaluated.

Another model would be a more regional and central station model. It could be publicly or privately owned, but it would operate out of a central station.

In this case, the station may cover subscribers over large geographic areas, GTE products in Stanford, Conn., for example, provides such a service.

Individual models, there are a number of companies that will provide a device which the client can purchase or lease that would be programed to directly dial for assistance. It would dial neighbors, friends, doctors, et cetera.

One is Micro Alert Systems in Burbank, Calif.

In other countries, these systems have undergone a variety of trials. In England, the Public Post Office Department and a number of private companies provide such services.

For example, in Stockport, England, the Department of Social Services operates a radio-monitored system for 4,000 home-bound elderly. Radio monitoring is justified in that case because of the poor quality of the telephone system and the long waiting list to get a phone installed.

Under that system, there are radio-equipped vans that go to respond to emergencies.

In the Scandinavian countries, Sweden, Norway, Denmark, the government is conducting relevant experiments. These systems are located within social service home health demonstration departments. They make use of telephones much like the model 1 that we evaluated.

With that, I end my testimony.

[The prepared statement follows:]

## OUTLINE OF STATEMENT BY JOHN N. MORRIS, PH. D.

### A. KEY ISSUES TO BE DISCUSSED

1. Overview of HRCA's involvement in studies of Personal Emergency Response Services; (a) NCHSR funded evaluation study in Boston and Cambridge and (b) Evaluation report of NCHSR funded study.

2. Assumptions concerning operation of system and persons requiring service.

3. Review of other providers of Personal Emergency Response Systems.

### B. DETAIL PRESENTATION

1. Assumptions concerning operation of system and persons requiring service.

(a) Services should be provided to persons who live alone, are functionally vulnerable and not isolated—those who benefitted in the NCHSR experiment.

Definition of Functionally Vulnerable—persons restricted in their ability to independently carry out one or more key activities.

Definition of Not Isolated—being in daily contact with others and if not seen would be checked on.

Key Impact Findings for Group to be Targeted for Personal Emergency Response Service.

These persons are likely to experience: Reductions in anxiety about what to do in an emergency; to be more satisfied with present living situations; to be more satisfied with life in general; to be less likely to have difficulty falling asleep, or waking up early and then not being able to go back to sleep; and to experience significantly fewer long-term institutional days (over 14 months had about one-half as many long-term or acute placement days as would have happened otherwise—14 vs. 26 days).

The cost benefit ratio for serving these persons based on 1979 dollars is 7.19 (or a benefit after costs are considered of about $114 per month).

(b) Key to success in the future based on experience from NCHSR study: Ceiling on reimbursement; prevention of sponsoring agency from using system as a case finding vehicle, e.g., prevent hospitals with lower utilization rate from using systems to bring persons with "Medicare" cards into the facility; and identify and serve persons who live alone, and vulnerable, and not socially isolated.

ESTIMATED DISTRIBUTIONS OF TG I AND TG II PERSONS

[In percent]

| | TG I—Live alone and vulnerable, not isolated | TG II—Live alone and vulnerable, isolated |
|---|---|---|
| Distribution in NCHSR supported study (1.3:1) | | ([1]) |
| General community population in Massachusetts (60-plus years of age) (3.4:1) | 5.5 | [2] 1.6 |
| Intake home care clients in Massachusetts (4.3:1) | 49.0 | [3] 11.3 |
| General community population (60-plus years of age): | | |
| One or more unmet needs | 53 | 68 |
| Two or more unmet needs | 31 | 50 |
| One or more moderate or severe unmet needs | 22 | 46 |
| One or more severe unmet needs | 4 | 13 |
| In untenable state, with important unmet need(s) and nonresponsive informal support systems | 13 | 28 |
| Intake home care clients in Massachusetts (60-plus years of age): | | |
| One or more unmet needs | 94 | 95 |
| Two or more unmet needs | 81 | 88 |
| One or more moderate or severe unmet needs | 71 | 76 |
| One or more severe unmet needs | 27 | 21 |
| In untenable state, with important unmet need(s) and nonresponsive informal support systems | 38 | 49 |

[1] 42.8 percent of vulnerable who live alone.

[2] 22.5 percent of vulnerable who live alone.

[3] 18.7 percent of vulnerable who live alone.

2. Review of other providers of Personal Emergency Response Systems.

a. When the HRCA NCHSR funded study of other personal emergency response systems was initiated there were about 2 or 3 other systems in the United States.

b. Lifeline at the present this time is by far the largest provider of Personal Emergency Response Services in the USA.

c. There are many other companies in the field—several have been modeled in part after the NCHSR recommendation study.

To acquaint AoA local AAA agencies with the new type of service AoA published memo IM 81-23 on January 4, 1981 was amended by IM 81-23-1 on September 10, 1981. These memos identified 15 companies as manufacturers of Personal Emergency Response Systems.

d. 3 Models Active (More in Models II and III than Model I):

(a) Community based medical model Hospital/health agency operates monitoring system for people in their community—integrated with other health/social services, e.g., Lifeline Systems, Inc., Waltham, Massachusetts.

(b) Regional/National Central Station Model Private/public owned central monitoring station—monitors subscribes over different size areas e.g., GTE Products Corporation, Stamford, Connecticut.

(c) Individual Model Client purchases/leases equipment that can be programmed to dial directly to friends/neighbors/doctors to call for help, e.g., Microlert System International, Burbank, California.

e. Other.

(a) Private companies and the Public Post Office Department in England and Scotland, Department of Social Services operates a radio monitored system for 4000 home-bound people (telephone system not of quality or coverage of system in USA).

Central Station with 6 radio equipped vans with warden (e.g., nurse) in the vans, go out to help with the emergency (also do friendly visits).

(b) Sweden/Norway/Denmark government conducting demonstrations on Personal Emergency Response Systems—by Social Service Home Help Departments over the phone (Model I). More social service than medically based—but handle all medical emergencies.

Chairman **JACOBS**. You are only 60 percent over your time. I do not think you are going to win the prize.

Thank you very much for your testimony.

Our next witnesses are from Lifeline Systems, Inc., Robert MacDonald, president, and Dr. Andrew Dibner, vice president.

### STATEMENT OF ROBERT MacDONALD, PRESIDENT, LIFELINE SYSTEMS, INC., ACCOMPANIED BY ANDREW DIBNER, VICE PRESIDENT, AND DANIEL H. MACCOBY, COUNSEL

Mr. **MACDONALD**. Thank you, Mr. Chairman. I am Robert MacDonald, president of Lifeline Systems, Inc. With me is Dr. Andrew Dibner, vice president of Lifeline, cofounder of the Boston University Gerontology Center, and inventor of the Lifeline concept.

Also here today is Daniel H. Maccoby, Lifeline's Washington counsel.

We welcome the opportunity to discuss the significant contribution that personal emergency response services are making in reducing Federal health care expenditures while providing important assistance to many elderly and disabled persons.

Lifeline Systems, Inc., has pioneered development of community-based personal emergency response services for the elderly and disabled since 1974.

Over the past 3 years, we have initiated service for over 18,000 people through 500 hospitals and community agencies in 47 States.

This rapid acceptance of personal emergency response services nationwide is indicative of their increasingly important role in the national health care system and makes these hearings particularly timely.

Lifeline Systems, Inc., supports H.R. 3921, which would provide Federal reimbursement for personal emergency response service to the many frail elderly who would benefit from the service.

With personal emergency response service, vulnerable elderly are more willing to be at home rather than in an institution.

Research studies and our experience have shown they can be discharged sooner from the hospital, and that nursing home usage is dramatically reduced.

Each year that appropriate individuals have the service, we believe there is an annual savings of over a $1,500 in health care costs.

Mr. Chairman, Dr. Young of HCFA estimated the first year costs of the legislation at $100 million, which assumes, I believe, using his figures, that 400,000 people would be using the service.

We feel that this number is unrealisticly high. Indeed, the Congressional Budget Office has estimated the first year cost of H.R. 3921 at only $5 million. But what Dr. Young failed to discuss was that 400,000 people using personal emergency response services would produce a $600 million savings in annual health care costs.

H.R. 3921 is targeted to help 1 million severely functionally disabled elderly who live alone. Approximately 80 percent of these elderly are women and often they are living on subsistence incomes. They want to continue living in their own homes, but they may be inappropriately institutionalized because of the fear that they will need help and will not be able to get it.

Often these individuals are only able to be at home because they are receiving home care and support services. Many should have 24-hour coverage, but such service may be expensive or unavailable.

Personal emergency response service provides 24-hour coverage at a low cost and helps many of these individuals stay in their homes.

A brief discription of the personal emergency response program may be useful to give the committee a better concept of the service. We provide a personal emergency response program which includes equipment, training and support material to hospitals, and other community agencies.

These agencies, in turn, provide the service to individuals in their communities. The equipment consists of a portable personal help button that is carried by the individual, a communicator which is attached to the telephone in the individual's home, and an emergency response center which is installed in the hospital and monitored 24 hours a day.

The button can be pressed from anywhere in the individual's house or yard. It is carried in the pocket or can be clipped to a belt. Our prototype can be worn on the wrist or on a pendant around the neck.

In an emergency situation, the individual presses the button, which sends a radio signal to the unit attached to the phone. This unit beeps to let the individual know the system has been activated. The Lifeline communicator then calls up the response center at the hospital. When the signal is received and verified, a message comes back to the individual to let her know that the alarm has been received at the hospital.

When the message comes in, the response center makes a call to the individual's home to see if she is able to get to the phone. If she is unable to, then a call is made to a responder.

The responder is a friend, neighbor, or relative—the informal network that Dr. Young spoke of.

The responder goes to the individual's house and provides whatever assistance is appropriate.

Chairman JACOBS. Why would the individual not call in the first place if she could?

Mr. MACDONALD. Although in many emergencies individuals may be able to get to the phone, they may be unable to dial. For example, a stroke victim may be confused and may not know whom to call. The personal emergency response system is built into that person's support network. System users feel comfortable with it and in an emergency, they feel they can just push that button and they will get in touch.

It automatically takes them to someone they know.

Chairman JACOBS. The phone company has that service now, does it not? Where you push the button and it automatically dials?

Mr. MACDONALD. That is correct, but it cannot be done from a remote location and it does not identify the individual or insure an appropriate response.

With the Lifeline system the responder gets to the home, he pushes the yellow reset button, which resets the unit and lets the hospital know that help has arrived.

We have a built-in timer that sends for help if the individual is unconscious or unable to call for help. The timer is set for 12 or 24 hours, depending on the individual's medical condition and is reset manually by pushing the reset button or automatically each time the phone is used.

The timer serves as a monitor of the user's well-being and provides strong psychological reassurance to the individual.

The psychological reassurance of being in touch with someone who cares is strengthened by monthly phone calls from the monitoring agency to the individual.

These personal calls build a bond between the agency and the individual and the result is that the individual feels more comfortable with the system.

Before Lifeline service was made available on a national basis, it was the subject of the 3-year, $640,000 National Center for Health Services Research study discussed by Dr. Morris. We believe the NCHSR study was one of the most rigorous evaluations ever done of a new home care service.

As mentioned by Dr. Morris, the study's findings were positive, especially for target group 2—persons who were severely functionally disabled but not socially isolated. This group of Lifeline users felt more comfortable about living alone and confident about continuing to do so.

These users averaged only 1 day of nursing home care compared to 13 days for the controls, and $1 of Lifeline service produced a savings of $7.19 in long-term care costs.

We believe that the elderly and disabled with target group 2 characteristics would be most likely to make use of personal emergency response services under H.R. 3921.

A recent national survey of 72 Lifeline programs confirmed the findings of the NCHSR study and supports Dr. Morris' contention that most Lifeline users are and will be Target Group 2 and will therefore experience significant cost savings.

In our survey, health agencies program coordinators estimated that nursing home use was delayed for 16 percent of their Lifeline subscribers and hospital stays shortened 9 percent.

Based on these results, and using current costs for hospital and nursing home inpatient days, we estimate that there is an annual per person savings for Lifeline users of $166 in acute hospital costs, and $2,090 in nursing home costs.

A number of States have also indicated that they believe personal emergency response services offer the potential for cost savings. They have used the service as a central component of State-funded comprehensive home and community care programs and have incorporated these services under section 2176, medicaid waiver projects.

In each case, the major incentive for providing the service has been expectation of savings in health care costs.

The growth of Lifeline programs and their use in demonstration studies is impressive, but it does not begin to meet the needs for personal emergency response services as a basic component of long-term care or to take advantage of the potential savings of health care dollars.

We recognize that many new programs are touted to save Federal funds and then they do not live up to those promises. We believe in this case there is sufficient research and experience to design a reimbursement mechanism that will both provide a needed service and save Federal health care dollars.

Thank you.

[The prepared statement follows:]

### STATEMENT OF ROBERT R. MACDONALD, PRESIDENT, AND DR. ANDREW S. DIBNER, VICE PRESIDENT, LIFELINE SYSTEMS, INC.

Mr. Chairman and members of the Subcommittee, Lifeline Systems, Inc. of Waltham, Massachusetts, is pleased to present testimony in support of H.R. 3921, a bill to provide Medicare (Part B) coverage of personal emergency response services for the severely functionally impaired. We welcome the opportunity to discuss the significant contribution that personal emergency response services are making in reducing federal health care expenditures while providing important assistance to many elderly and disabled persons.

Lifeline Systems, Inc. has pioneered the development of community-based personal emergency response services for the elderly and disabled since 1974. Over the past three years, we have initiated service for over 18,000 people through 500 hospitals and community health agencies in 47 states. This rapid acceptance of personal emergency response services nationwide is indicative of their increasingly important role in the national health care system, and makes these hearings particularly timely.

Personal emergency response services allow frail or disabled persons to live with independence and security in their own homes because they are linked through an electronically operated monitoring system to an array of community-based health services and because the system makes possible immediate intercession by relatives, friends or neighbors in the event of a medical or environmental emergency.

These services have the potential for ameliorating the fears of perhaps one million older Americans—persons who are functionally disabled, living alone and at risk of institutionalization. Most of these elderly are women, often on subsistence income, who are unable to pay for home health services. Many have lived for years in the same residences and have no desire to enter long-term care institutions as long as they can feel secure about their ability to obtain immediate assistance, should it become necessary.

Similarly, many frail elderly or disabled persons who require hospitalization would like to return home at the earliest possible time. Physicians acquainted with the benefits of personal emergency response services have shown a growing willingness to discharge their patients earlier than normal if the patients already have a response system or are willing to have such a system installed in their homes.

In addition to the obvious psychological and social benefits of these services, there is substantial evidence, based on an extensive study sponsored by the National Center for Health Services Research (NCHSR)[1] and on subsequent experience, that appropriate use of personal emergency response services can create annual health care savings of over $1500 per person— much of which would accrue to Medicare and Medicaid—through reduced use of institutional and community services. Such evidence indicates that H.R. 3921 would not only provide important assistance for the elderly and disabled, but would also result in net savings for federal health care expenditures.

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[1] Sherwood, S. and Morris, J. N. "A Study of the Effects of an Emergency Alarm and Response System for the Aged." Final Report to the National Center for Health Services, Hebrew Rehabilitation Center for the Aged, Boston, Mass. 1980.

The Lifeline personal emergency response system works as follows: A hospital or other 24-hour health or social agency in a community operates an emergency response center which is linked to home units whose users pay a monthly fee for the monitoring service. In case of emergency, the user presses a portable button which sends a radio signal to an electronic communicator connected to the telephone. This radio signal has a range of 200 feet so the person can signal from any place in the home or yard. The communicator automatically seizes the line, calls the response center and identifies itself. The response center operator retrieves the client information file and calls the home. If there is no answer, or if the client confirms the need for a response, the operator calls "emergency responders" designated by the monitored individual as people who are able to respond quickly in an emergency. (Lifeline research has shown that the majority of emergency calls do not require the expense of an ambulance or other emergency medical services). Responders are usually friends, neighbors or relatives. Upon arrival at the monitored person's home, the responder presses a flashing "reset" button which notifies the center that help has arrived. The center then serves as a back-up to send formal help if needed.

The Lifeline unit is also designed to call for help even if the person cannot press a button. A timer, set at 12 or 24 hours, is responsive to unusual inactivity in the home and will automatically call for help if the person has not "checked in" daily by pressing a button. Normal telephone use also automatically resets the timer.

In sum, personal emergency response services constitute a major medical and psychological support system providing: 1) family and community support; 2) coordination of medical and social service responses; 3) 24-hour-a-day monitoring; 4) instant programmed response to emergencies; and 5) regularized updating of clients' data files.

The use of Lifeline personal emergency response services is now supported largely by private funds—provided by individual users, hospitals, private health agencies, private foundations and community organizations—but also by public funds—provided through the Older Americans Act, state appropriations, and Medicaid-waiver coverage.

Most hospitals and other Lifeline providers charge a service fee of approximately $10–$20 per month for subscribers. Volunteers also play an important role in many programs, doing installations, making monthly calls to clients to test the system, and providing in-home instruction and service.

A recent national survey[2] of 72 Lifeline programs monitoring 2269 persons gives an indication of the population currently using personal emergency response services and of their experience with the service. The survey found that the average Lifeline subscriber was in his or her 70s and that 80 percent were women and 20 percent were men. Over 90 percent of the subscribers lived in their own homes or apartments. Seventy-nine percent of the subscribers lived alone; 11 percent lived with spouses and 9 percent lived with other relatives or friends. Each Lifeline user had an average of 1.85 disabilities, the most common involving cardiac and mobility impairments. Approximately one-third of the subscribers had at least one serious emergency each year, and the average rate was .84 emergencies per person per year on the system. Ninety percent of the studied emergencies were medical and 10 percent were environmental.

In 60 percent of the emergencies the person could be helped at home, but in 40 percent the patient was brought to the hospital. Twenty-four percent of emergencies were judged to be life threatening. Emergency problems were varied, but by far the most frequent were falls, followed by heart attacks and respiratory problems.

Over 98 percent of subscribers said they were satisfied or very satisfied with the service, and many stated that it had been a critical factor in their ability to maintain themselves at home alone.

## COST EFFECTIVENESS

Personal emergency response services were subjected to rigorous evaluation in the three-year, $640,000 NCHSR-sponsored study, which compared 200 functionally impaired and medically vulnerable elderly who lived alone but had Lifeline (experimentals) with an equivalent group of controls who had no personal emergency reponse service. The experimental group, compared to controls, showed significantly greater confidence in living alone, had dramatically fewer days of nursing home care, and experienced lower overall health care costs. The largest group studied—severely functionally impaired but not socially isolated—realized the greatest benefit/cost ratio: $7.19 saved for every $1 invested in the personal emergency response service. This group represents the largest percentage of the severely functionally impaired population nationally that would be eligible for benefits under H.R. 3921. The experimental group also averaged only 1 day of nursing home care during the test period, compared to 13 days for the control group. The experimentals decreased their use of health and social services compared to the controls. They used fewer acute hospital days, chronic and rehabilitation hospital days, nursing home days, and units of home health care. The annual savings for this group (in 1978 dollars) was $1,546 per person.

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[2] Dibner, A. S. "A National Survey of Lifeline Programs." Lifeline Systems, Inc., Waltham, Mass. July 1982.

The NCHSR-sponsored study concludes that personal emergency response services represent an important addition to the continuum of home and community care, and significantly reduce health care costs for the severely functionally impaired.

The follow-up national survey of 72 Lifeline programs confirmed the findings of the NCHSR-sponsored study. Health agency program coordinators estimated that nursing home use was delayed for 16 percent of the sample and acute hospital stay shortened for 9.0 percent. Using current costs for hospital and nursing home inpatient days, it was estimated that there is an annual per person savings of $166.50 per year in acute hospital costs and $2,090.84 per year in nursing home costs for those on Lifeline. Based on these figures, which are similar to those found by the NCHSR-sponsored study when adjusted for inflation, the 18,000 persons currently on Lifeline programs nationally could be generating over $40 million annually in cost savings in institutional care. Certainly, the cost of Lifeline personal emergency response services is minimal compared to the real and potential savings from reduced dependence on institutional care. The cost of the equipment alone can be recovered in several months while the annual savings can be realized for the life of the equipment, which is in excess of five years.

These cost-savings findings clearly have important implications for H.R. 3921. The reduced incidence of institutionalization by those severely functionally impaired individuals eligible for Medicare coverage under the legislation could result in significant savings for Medicare and Medicaid. Indeed, the substantial potential savings of nursing home costs suggest that Congress may also want to consider Medicaid coverage of personal emergency response services.

A number of states have indicated that they believe personal emergency response services offer the potential for cost savings by using the services as a central component of state-funded comprehensive home and community care programs. Florida's Community Care for the Elderly program, Texas' Alternative Care Program, and California's Multipurpose Senior Services Project are examples. Through case-managed comprehensive home care, these states have used personal emergency response services to effectively substitute for more costly personal care attendants and to make the home a more secure environment for the chronically disabled, thus avoiding or postponing care in health institutions.

New York, Colorado, Kansas, Massachusetts, and Utah have incorporated the use of personal emergency response services in applications for Section 2176 Home and Community Care Medicaid Waiver projects. New York has also requested a Medicare waiver for personal emergency response services in a HFCA-sponsored social/HBO project. In each case, the major incentive for providing the service has been the expectation of savings in health costs.

## CONCLUSION

Personal emergency response services represent an innovative, cost-effective contribution to home health care. These services have developed through a blend of modern technology, good social planning, the persistence and good management of private enterprise, a substantial research effort funded by the federal government, and widespread grass-roots support by local hospitals, agencies and community volunteers. Although many thousands of disabled elderly are benefitting from personal emergency response services, they represent only a small fraction of those in need. Federal support is necessary to ensure the availability of these services to the severely functionally impaired.

Based on careful federally-sponsored research and on our experience throughout the country, we believe that federal governmental support of personal emergency response services for the severely functionally impaired, in cooperation with the private sector, can play an important role in reducing inappropriate institutionalization and in conserving federal and community health care resources. Medicare coverage of personal emergency response services under H.R. 3921 is an important step in providing federal support for these services.

Chairman JACOBS. Subtracting my 42 seconds of conversation with you, that makes you 8 minutes, 20 seconds. At this point, without objection, statements by Claude Pepper, chairman of the Aging Committee, will be included in the record.

[The statements referred to follow:]

### STATEMENT OF HON. CLAUDE PEPPER, CHAIRMAN, SELECT COMMITTEE ON AGING

Mr. Chairman, I am pleased to have this opportunity to speak in support of H.R. 3921, a bill I introduced with Mrs. Heckler to provide Medicare coverage of personal emergency response services.

I believe this proposal, which now has 40 cosponsors, offers the Federal Government a unique opportunity to join with the private sector in supporting services which can help to improve the quality of life for the elderly and disabled and, at the same time, have a positive impact on the Federal Budget.

As you know, Mr. Chairman, Government expenditures for institutional health care for the elderly have grown markedly in recent years. In 1981, hospital services cost the Medicare program nearly $28 billion. The Nation's nursing home bill—about one-half of which was paid by Medicaid—exceeded $24 billion that year.

Efforts to better allocate increasingly scarce health dollars have brought many of us to strongly support home care alternatives and it is in this context that personal emergency response services should be considered.

Although the details of these services may vary somewhat, the essential purpose is to permit an individual at home to summon assistance automatically in the event of a medical or other emergency. The utility of such a service is clear. Elderly or disabled persons with physical or mental infirmities but no need for around-the-clock care frequently enter nursing homes simply to insure 24-hour monitoring in the event an emergency should arise.

A system such as this can permit these individuals to remain independent in their own homes, secure in the knowledge that help is at home. If used as part of a hospital discharge plan, the service can also facilitate a patient's early return home.

A recent study sponsored by the National Center for Health Services Research strongly supports the conclusion that this service can assist the severly impaired elderly and disabled to remain at home and reduce reliance on institutions. The study evaluated the effects of a system known as "Lifeline." This particular system allows clients to request aid by simply pressing a button on a portable pocket-size unit. If the person is unconscious, the system senses the inactivity over a period of time and signals for help automatically. In most cases, help will come from a relative or neighbor who has been designated by the individual, thereby reducing the use of expensive police or emergency units.

Personal emergency response services offer advantages to persons of virtually every age and physical condition. But our bill, H.R. 3921, would limit Medicare coverage to those individuals for whom the service would be most beneficial and cost-effective—severely functionally impaired persons who are living alone or are left alone for substantial periods of time.

The government-sponsored study of this system suggests the potential for savings in both Medicare and Medicaid under H.R. 3921. I believe this service could prevent or shorten hospital stays, discourage unnecessary nursing home care, reduce the need for formal home health care, and diminish the incidence of visits to emergency rooms for non-emergency care.

Unfortunately, in estimating the cost of this bill, the Congressional Budget Office has declined to consider the potential offsetting savings suggested by the study. But it is my hope that you will take these factors into account in your own deliberations.

The concept of "cost avoidance" must begin to have a place in our thinking as the aged population grows. Persons 85-and-over represent the fastest growing segment of the U.S. population, and it is they who are most likely to need long-term care. We simply cannot continue to rely on institutions to meet their needs; we must develop creative alternatives. Emergency personal response services can be one element of a new approach.

But cost alone should not guide our thinking. By helping to make this service available, we could begin to restore the sense of security many people lose as they grow old. Those who studied this system for the government reported that its users felt more confident about living independently. They had better sleep patterns and moved around their homes with greater ease.

Mr. Chairman, the final form this legislation takes may be debated, but we should support the concept if for no other reason than the peace of mind it would bring to the many elderly people whose dearest wish is simply to be at home.

## STATEMENT OF HON. CLAUDE PEPPER, CHAIRMAN, SELECT COMMITTEE ON AGING

Mr. Chairman and members of the Subcommittee, I am pleased to be here today to discuss legislation I have introduced, with Mrs. Heckler, that would provide Medicare Part B coverage of personal emergency response services used by the severely functionally impaired. I am also especially gratified that the Committee is taking this opportunity to highlight the role of personal emergency response services in the continuum of community health care and to consider appropriate participation by the federal government in the provision of these services.

The rapid growth of federal expenditures for institutional health care increasingly has led the health care community and Congress to consider in-home and community-based alternatives to nursing homes and hospitals that would be less expensive while at the same time better meet the needs of health care recipients.

Personal emergency response services represent precisely the kind of alternative care that can help improve the quality of life for the elderly and disabled while reducing the overall costs of long term care. H.R. 3921, which now has 40 co-sponsors, offers the federal government the opportunity to participate with the private sector in supporting these services for those most at risk of institutionalization. Indeed, through this support, the federal government has the proven potential to avoid the significantly higher institutional and other health care costs it would otherwise incur on behalf of these service recipients. Thus, we have the rare opportunity of helping people and having a positive impact on the federal budget at the same time.

Although the details of personal emergency response services may vary somewhat, the essential purpose of the service is to permit an individual at home to summon assistance automatically in the event of a medical or environmental emergency. The utility of such a service is clear. Elderly or disabled persons with physical or mental infirmities but no need for around the-clock care frequently enter nursing homes simply to insure 24-hour monitoring in the event an emergency should arise. A personal emergency response service can permit these individuals to remain independent and in the community, secure in the knowledge that assistance can be summoned by the push of a button. If used as part of hospital discharge planning, the service can also facilitate a patient's early return home.

A recently completed study sponsored by the National Center for Health Services Research (NCHSR) strongly supports the conclusion that personal emergency response services can assist the elderly and disabled to remain independent in their own homes while reducing the incidence of institutionalization and creating significant savings in health care costs for the severely functionally impaired. The study, conducted by Drs. Sylvia Sherwood and John Morris of the Hebrew Rehabilitation Center for Aged in Boston, evaluated the effects of a particular personal emergency response system known as "Lifeline." This specific system allows clients to request aid by simply pressing a button on a portable pocket-sized unit; if the person is unconscious, the system senses the inactivity over a period of time and signals for help automatically.

In greater detail, the system tested by the study works as follows:

The personal emergency response service client normally carries a miniature wireless call button that can be worn on a chain or attached to a belt or other article of clothing. When help is needed, the client presses the button and a small machine attached to the telephone receives the wireless signal, captures the phone line, and sends a digital message over the phone line to a community-based 24-hour emergency response center (such as a hospital's emergency switchboard) where the message is automatically printed.

Response center personnel read the client code from the printed tape and retrieve the client information card with name, address, telephone number, a brief statement of medical or physical problems, and a list of responders. These responders are designated by the client at the time the system is installed. Included are people with whom the client is comfortable and who have indicated their willingness to respond in the event of an emergency. Also on the list are municipal agencies, such as police and ambulance services, which can provide assistance in the event that the volunteer responders are not available.

On receipt of the alarm, a response center worker immediately places a call to the client. If the client can get to the telephone, the coordinator evaluates what help may be needed and responds accordingly. If the client is unable to answer the phone, the coordinator assumes that the client is injured and unable to move. Immediate action is taken to contact a responder who can arrive on the scene quickly.

In the event that the client is unconscious and unable to press the button, a clock-timer in the Lifeline equipment at the client's home will initiate an emergency call. The timer can be set for 12 or 24 hours and is reset manually by pushing the reset button on the unit. Lifting the telephone handset during normal use also automatically resets the timer.

The NCHSR-sponsored study made several significant findings of particular significance for H.R. 3921:

1. *Psychological Benefits.* Personal emergency response service users felt more confident about continuing to live independently. They reported better sleep patterns and moved around their homes with greater ease.

2. *Reduced Need for Institutional Care.* The largest group of tested personal emergency response service users—severely functionally impaired and not socially isolated—averaged only one day in a nursing home compared to an average of up to 13 nursing home days for non-service users during the 13-month testing period.

3. *Cost Benefits.* For the largest group tested, each $1 spent for personal emergency response services produced a savings of $7.19 in total long-term care costs due to reduced use of both institutional and community services.

4. *Screening Instrument.* The researchers developed a brief, reliable screening questionnaire to identify potential personal emergency response service users with the greatest need and who would benefit most from such a service.

Personal emergency response services can clearly offer advantages to people of all ages and physical conditions. However, H.R. 3921 would limit Medicare coverage of personal emergency response services to those individuals for whom the services would be most beneficial and cost effective: severely functionally impaired persons who are living alone or are left alone for substantial periods of time.

The NCHSR study concluded that those who were severely functionally impaired and not socially isolated (Target Group II in the study) derived the greatest economic benefit from personal emergency response services: $7.19 in health care savings for every dollar spent on the response services. This category of severely functionally impaired persons represents approximately 75% of the severely functionally impaired population nationally that would be eligible for services under H.R. 3921. (Experience and research has shown that the remaining 25% tend not to participate in the health care system generally and are therefore less likely to make use of personal emergency response services.)

The NCHSR-sponsored study's analysis of the economic impact of personal emergency response services on overall health care costs makes clear the potential for federal health care savings under H.R. 3921. To the extent that these services reduce the incidence of acute hospital care, for example, Medicare expenditures will be avoided. To the extent that the services reduce the need for institutionalization in skilled or intermediate care nursing homes, Medicaid expenditures (for Medicaid eligible persons) would be saved. Similar savings could result from reduced use of formal home health services.

The chart below, based on findings of the NCHSR-sponsored study gives an indication of the kinds of savings that could result under H.R. 3921 from use of personal emergency response services by the severely functionally impaired but not socially isolated. (As noted above, this category would likely make up 75% of the eligible population under the bill and a higher proportion of the user population.)

*Savings in annual per person health care costs resulting from use of personal emergency response services*

[In 1978 dollars]

| Service: | *Cost saving* |
|---|---|
| Acute hospital care | $384 |
| Chronic and rehabilitation hospital | 511 |
| Nursing home SNF | 121 |
| Nursing home ICF | 80 |
| Formal home health care | 450 |
| Total | 1,546 |

NOTE.—The Congressional Budget Office, which estimated Federal outlays under H.R. 3921, declined to estimate the potential offsetting savings resulting from reduced incidence of institutionalization, thus the CBO figures do not incorporate the results of the NCHSR study.

H.R. 3921 recognizes the importance of integrating personal emergency response services with other community services in the continuum of care. Therefore, the bill requires that personal emergency response services be provided by an agency that carries out health, social service or public safety functions (e.g. a hospital, nursing home, health or social service agency, or the police or other public safety agency) and that the agency providing the personal emergency response services be located in the same community as the individuals it serves.

The requirement that the personal emergency monitoring agency be locally-based should be read broadly and is meant to maintain, to the extent practicable, the community health-care base for personal emergency response services. Obviously, in many parts of the country with low population density, the personal emergency monitoring agency may well be located a hundred miles from the user of the service, and the bill would still cover this service. However, the legislation would not permit the monitoring agency to be simply a telephone answering service or agency located on the other side of the country where responders merely inform the police in the caller's town when an emergency call is monitored.

The bill's definition of personal emergency response service is based on the kind of service found by the NCHSR-sponsored study to be both reliable and highly effective. The legislation requires that personal emergency response services incorporate certain components that will help ensure this effectiveness and encourage proper utilization of community resources. Thus, for example, the service must include a passive component that will automatically notify the emergency response monitoring agency if an individual's home unit has not been reset after a given period of time (e.g. 12 or 24 hours). This helps guarantee that even if a user is unable to signal for assistance due to sudden incapacity, help will still arrive within a short period of time.

The legislation also encourages personal emergency response service users to specify persons who should be notified in the event of an emergency—such as a neighbor or relative who lives nearby. Through this system, expensive community resources such as the police or emergency squad are less likely to be called automatically where friends, relatives or neighbors can respond to a call from the personal emergency monitoring agency.

The NCHSR study found that the kind of personal emergency response service identified by H.R. 3921 was particularly effective and created significant cost benefits for the severely functionally impaired. To best target Medicare coverage of the service on this particular population, the bill requires that a physician, clinical social worker, or other qualified personnel, as specified by the Secretary, certify that a potential recipient of Medicare-supported personal emergency response services meets the eligibility standards established by the legislation.

It is clear that personal emergency response services can assist the frail, at-risk elderly and disabled to live independently in the community and to avoid inappropriate institutionalization while reducing long-term care costs. Limited federal support of these services will help ensure their availability for the severely functionally impaired who will most benefit from both an economic and social perspective. Medicare coverage could create savings (or cost avoidance) that would accrue both to Medicare and Medicaid. Indeed, given the savings in skilled nursing and intermediate care facilities resulting from the use of personal emergency response services, Medicaid coverage might also be appropriate.

Mr. Chairman and members of the Subcommittee, the precise form of federal support for personal emergency response services may be debated, but the concept should have the full support of Congress. I appreciate the opportunity of appearing here this morning and I look forward to working with you as we seek to implement the goals of H.R. 3921.

Chairman JACOBS. At this point, I say for edification of the witnesses, that I will illustrate the problem we have. There was a meeting during a political primary where they had 113 candidates for the State legislature. It began at 7:30 in the evening, when it got to be 3 in the morning, the fellow who waited patiently, finally made his talk and there was one person left in the room besides himself.

He said, "I want to thank the audience and that is you, sir, for having the courtesy to stay here and hear me out."

To which that person responded, "Don't thank me, I am the next speaker."

So that is the problem we have here. Anyone who takes more than the 5 minutes is doing no kindness to the people at the other end of the agenda.

Mr. Rangel.

Mr. RANGEL. Thank you, Mr. Chairman.

Is there any difference between this Lifeline system and some of the systems that are hooked into the regular burglar alarm system for the police? Could it not work the same way for the hospital?

Mr. MACDONALD. The Lifeline system is not a burglar alarm. Although the Lifeline communicator that attaches to the phone line in the individual's home is similar to some burglar alarm equipment that automatically dials, the push button the individual has is a special Lifeline component, and the timer that automatically determines inactivity is another important component.

Most importantly, it is the programmatic aspect of Lifeline which involves the hospital and the other agencies in the community that is essential to the success of personal emergency response services.

Mr. RANGEL. Thank you.

Mr. MACCOBY. I'd like to make a brief comment on the relationship between the National Center for Health Services Research Study and this legislation. I am not sure that the Health Care Financing Administration statement made this relationship clear.

Dr. Young noted that the proportion of all handicapped and elderly persons for whom personal emergency response service was most effective was relatively small.

What he did not mention, however, is that the legislation, H.R. 3921, only covers the small proportion of the elderly and handicapped population who benefit most from the service: Specifically the severely functionally impaired who number under 1 million.

The largest group tested by the NCHSR study—the severely impaired and not socially isolated—are the very people who would, in fact, be eligible for services under H.R. 3921 and who would derive the most cost benefits—$7.19 in savings for each $1 spent on the service.

Therefore, the legislation does carefully target the group for which there would be significant cost benefits, a reduction in nursing home care days, and additional psychological benefits.

Chairman JACOBS. Your point is well taken.

Did you have something, sir?

Dr. DIBNER. I would just like to make one comment, sir, concerning Dr. Young's recommendation that the Government could further demonstrate personal emergency response services as a component of ongoing comprehensive care packages, such as the channeling program.

There is one problem with this approach.

When you provide an array of services, it is very difficult to tell which of them in particular have positive effects and which do not.

However, the particular study that has been mentioned—the NCHSR-sponsored study—focused on one service only—personal emergency response services.

Because the experimental group was receiving that one service whereas the control was not, the study could demonstrate that personal emergency response services were cost-effective with a particular group.

Chairman **Jacobs**. Fine; we thank you for your testimony.

Our first panel is represented by James Schmidt, administrator, St. Vincent Stress Center. And we have the Bethesda Hospital from Cincinnati, Ohio, Kathleen Mueller. And Mrs. Potter.

Ms. **Potter**. Yes; I am she.

Chairman **Jacobs**. You know, you have one in your home.

Ms. **Potter**. I have a Lifeline in my home, yes.

Chairman **Jacobs**. So we will find out from you.

Please proceed.

## STATEMENT OF KATHLEEN M. MUELLER, R.N., B.S.N., M.B.A., MANAGER OF GOVERNMENT RELATIONS, BETHESDA HOSPITAL AND DEACONESS ASSOCIATION, CINCINNATI, OHIO

Ms. **Mueller**. I am Kathleen Mueller, manager of Bethesda Hospital and Deaconess Association, Cincinnati, Ohio. I am pleased to have this opportunity to present our views on personal emergency response systems.

Bethesda Hospital and Deaconess Association has participated in the Lifeline system as an emergency response center for 2 years.

Bethesda has what is considered by some people to be a model Lifeline program. The hospital has made a real commitment to the community. Our program provides 24-hour access to community medical services for Lifeline subscribers.

A $15 monthly maintenance fee, paid by the subscriber, is the break-even cost to cover the operating expenses. We bill our subscribers for the monthly fee by providing them with 12 envelopes for the year.

Each month, they send in their check in the envelope provided. A minimum amount of accounting is involved.

The Bethesda Hospitals Auxiliary has funded the capital cost and continues to purchase the individual home units while hospital volunteers install and maintain the equipment.

Bethesda currently has 160 Lifeline subscribers who have been referred by hospital personnel, social workers, Hospice of Cincinnati, community agencies and families.

Eighty-six percent are over 65 years of age. Of those over 65, 53 percent are over 80. Eighty-four percent are female.

The subscribers are socially isolated, they either live alone or are alone for long periods of time, and they all have some functional disability. Age is an important factor in patient selection, but not the sole indicator.

Bethesda Lifeline has allowed certain subscribers to remain independent, to feel more comfortable in their home situation and to feel more confident about continuing to live alone.

I would like to tell you, briefly, about one of our subscribers, Loretta. Loretta is a delightful 58-year-old woman who is paralyzed on one side from a stroke. She is confined to a wheelchair. She lives alone, and is essentially isolated except for a few friends and the homemaker that comes in once a week for 4 hours.

She credits Lifeline with saving her life in the following situation:

The dosage of a medication that she had taken for years was increased. She became disoriented and continued to increase the dosage until she began to lose consciousness and fell out of her wheelchair.

She managed to push her Lifeline button and the emergency response service was triggered. When the police arrived, they took Loretta to the hospital in a nearly unconscious state. The doctor told her she might have died if help had been delayed another day or more.

Loretta said, and I quote, "I would rather give up $15 of my food money each month than give up my Lifeline system. Having it with me makes me feel just like anyone else—independent."

Bethesda would like to offer several recommendations regarding emergency response systems.

Personal emergency response systems should be encouraged. The use of Lifeline enables certain individuals to maintain their independence and quality of life by allowing them to live in their home—the preferred lifestyle of most Americans.

We see a system, such as Lifeline, as being a reinforcement of community long-term care, which refers to services oriented toward assisting an older person to live in a noninstitutional setting.

There is a consensus at Bethesda, from our experience, that perhaps Lifeline, in and of itself, does not necessarily keep disabled and frail elderly persons out of institutions.

However, Lifeline, which could be termed both a social and medical support program, when used in conjunction with other resources such as visiting nurse service and meals-on-wheels, does reinforce community long-term care thereby possibly postponing, delaying or perhaps even eliminating the need for the institutional long-term care.

Through careful client selection, the concept of community long-term care, which is more cost effective than institutional long-term care in the long run, would be reinforced.

Medicare funding of Lifeline might promote a national program that would make the service available to many more individuals across the country.

Our second recommendation: We suggest that strong consideration be given to medicare reimbursement for the capital equipment costs only under the medical equipment provisions of the present law.

The monthly operating costs would then be paid by the subscriber. For those subscribers unable to pay the fee, perhaps other community resources could be utilized, such as local funding through the Older American Act.

Our concern, relative to the reimbursement of the monthly charge, is that with few incentives from the patient's point of view, there is no adequate safeguard on overutilization. In addition, the current billing requirements of medicare are such that it would be cost prohibitive for the hospital to have the monthly operating costs reimbursed.

Our third recommendation which is also a response to Mr. Rangle's question regarding the difference between a burglar-alarm type system and Lifeline: We would like to emphasize the importance of maintaining the language in the proposed legislation that stipulates that an agency reimbursed for providing personal response services does so only as an incidental part of health social service or public safety functions conducted by the agency.

The medical aspects of the system require this link.

We have also found that the Lifeline coordinator and volunteers in the home frequently act as referral agents to other community resources. People working with the subscribers thus require firsthand knowledge of community resources for maximum benefit of the system.

Subscribers would lose an important link to other community resources if an emergency response system was not affiliated with a health or social service agency.

Thank you for this opportunity. I have tried to be brief in telling you about our program and recommendations.

If you have any questions now or in the future, I would be happy to attempt to answer them.

I have tried to be brief, Mr. Chairman, thank you.

Chairman JACOBS. Thank you, Ms. Mueller.

## STATEMENT OF JAMES A. SCHMIDT, ADMINISTRATOR, ST. VINCENT STRESS CENTER, ST. VINCENT HOSPITAL AND HEALTH CARE CENTER, INDIANAPOLIS, IND.

Mr. SCHMIDT. Thank you.

Mr. Chairman, members of the committee, I am Jim Schmidt, administrator of the St. Vincent Stress Center in Indianapolis and I represent both St. Vincent Hospital and St. Vincent Stress Center.

Given the comments that have been made previously, I will digress from the written words and still try to win that dollar award. I would like to mention just a couple areas.

One, we have seen a Lifeline system develop the support system for elderly people in a community. We have used it in our hospice program and have seen it reduce the cost of home care and permits a better allocation of home care man-hours.

We have seen it used with cardiology patients which has permitted earlier discharges. We have seen it with brittle diabetics. Our first Lifeline patient was blind and deaf, his wife was legally blind and the patient and family are still in a home environment.

Mr. Chairman, members of the committee, we urge your support of this piece of legislation.

Thank you.

[The prepared statement follows:]

### STATEMENT OF JAMES A. SCHMIDT, ADMINISTRATOR, ST. VINCENT STRESS CENTER, INC.

The St. Vincent V-Line program has been operational since November, 1981. Currently there is a waiting list.

Our subscribers range in age from 35 years to 92 years old. The majority of our subscribers being in their 70's and 80's are able to live independently in their own home or apartment; however, feeling more secure knowing the assistance from V-Line is only minutes away. Of the installed units, 72 percent are in homes of female subscribers, 22 percent in males and 6 percent are in the home of couples. Approximately 95 percent are elderly and 5 percent are handicapped; blind, paraplegic, quadriplegic, brittle diabetic and severe heart problems.

A unique service St. Vincent has been able to provide is that of offering our V-Line system to families and patients in our Hospice Program. Six Hospice families have been on the V-Line system, 3 family members of the elderly patients decided to have the V-Line remain in their home after the death of their spouse because they were so pleased with the service and it had given them full-time assurance that help was nearby during the time they cared for their terminally ill loved ones.

The subscribers on the system live within the St. Vincent service area. This provides opportunities for direct person-to-person contact. In many situations, the program has developed for subscribers a support system which did not previously exist. It has provided not only a link to help but has provided social and psychological support as well.

Often we have found isolated elderly who had "no one" to respond if a crisis occured. In talking with neighbors we found no one willing to assume responsibility on a continuing basis, but everyone was willing to help in an emergency. The V-Line has provided that link. What has happened in reality is that the neighbor who volunteered to "help in an emergency" stops by periodically to see how things are going. The isolated elderly person is now much less isolated and ofter is involved with new friends and families.

In the 13 months that our system has been in operation, we have had many emergency calls from subscribers. Most of them needing minor assistance i.e., help from falling out of a wheelchair, falling down from walking, needing a neighbor's strong arm to get up and questions about dropping the portable button and needing assurance the equipment is still working. We have had some critical emergency situations. One that involved physical abuse to an elderly woman, another involving the subscriber going into a diabetic coma and the Emergency Medical Techs revived her when they arrived and others with severe medical probelms that used V-Line for an immediate response that got them to the hospital where they were quickly admitted for care.

About 25 percent of our subscribers are self-referred, 45 percent come from family members and the rest are from community agencies, neighbors, friends and physicians.

St. Vincent Hospital employees have also been able to benefit from the V-Line system the hospital offers. Several relatives of employees have V-Lines in their home. These employees feel confident knowing that while they work a frail elderly family member is in touch with the hospital and that they can be easily reached and become involved in case of an emergency.

One of our first recipients of St. Vincent V-Line was a blind and deaf man living with his partially blind wife and teenage son. With the V-Line, the couple have one more link to the world outside their small home. In spite of their many handicaps, they have not retreated from life. They frequently visit friends and relatives. Members of the church to which they belong drive them to services and other social gatherings. Mr. R. is an avid reader of books and magazines in Braille and both enjoy working in their vegetable garden. Mrs. R., whose sight is limited, relies on buses knowing the V-Line system is in the home. Mr. R. now can be more mobile in her absence—walking in the yard, or working in the garage or basement knowing his portable button can bring immediate assistance as long as he is within the 200 feet of the Lifeline equipment which is in their bedroom.

In the St. Vincent V-Line program, volunteers help in every area of the operation—installations, phone interviewing, paperwork, presentations to community groups and monthly phone call checks. The volunteers time and commitment have been invaluble to the hospital and the subscribers report how much they appreciate the caring attention they receive.

Chairman **Jacobs**. That is 47 seconds. Looking good.

Ms. Potter, you look good before you say a word.

## STATEMENT OF KAROLINE K. POTTER, WHEATON, MD.

Ms. **Potter**. I am Mrs. Karoline K. Potter, 11709 Kingtree Street, Wheaton, Md. I am 64 years old, a retired Federal employee having retired a little over 2 years ago.

My last employment was with the agency NOAA. I belong to St. Luke's Lutheran in Silver Spring and it is through them I learned about Lifeline, and the Takoma Park Citizens Club.

If I did not have this personal emergency response system, it would be necessary for me to be in a nursing home. With this emergency response service, neighbors can respond, which is very often, with all the help I need.

Having been stricken with polio at age 32 years, through the years, there has been gradual aging process that took away slowly the ability to handle all situations of life.

My son married in 1967 and I have been alone since that time. I have had falls to the floor and managed to crawl to my couch in the living room. It is harder to do that now since I can easily slip.

Now that I have this personal emergency response service in my home, I know that all I have to do is push a button and help will come.

Not only will the help come, but expediency of their arrival is the most important part of this system. Think of how time is such an important factor, many, many dollars are saved in emergency treatment.

Just to know that should I feel a stroke coming on or having slipped out of a chair, gives me peace of mind.

With medical costs what they are in the emergency rooms, and I have had nine ambulance rides, I know what that is, medicare can profit greatly by less reduction of their funds in emergency treatment.

Having the telephone company come to your house and install a jack for hookup to this personal emergency system costs only approximately $52 and you pay $10 a month for use of the equipment, enabling help to come in a matter of minutes, which can save thousands of dollars for medicare.

How better can you treat an older person who has enjoyed the freedom of living by still remaining as independent as they have for 50 or 60 years.

This alone can save depression which is so prevalent in people in the nursing homes. I for one can speak, to take away my independence, severe trouble will start. I have been an independent person and I believe I am what I am and where I am today because of God's help to me for wanting to help myself.

Many people in nursing homes have had to have help from medicare but could probably be living at home in an apartment by themselves if they just had this emergency response system.

As one man stated in the first anniversary program of Lifeline, it should be called the line of life, it helps life to be maintained in the American way.

For this reason, asking medicare to pay for this minimum charge for such voluminous help, and the help that this instrument gives proves to be a meager amount compared to the hundreds of thousands of dollars they can pay for being found too late, and facing nursing home expenses as well as the mental torment connected with a catastrophe.

There is one other item I would like to state. On the 1st of August 1979, a 19-year-old mental case broke into my home. Had I had this Lifeline system, I could have just reached over and hit the button and help would come. As it was, I had to cope with him and managed to talk him into sitting down until I could call the police and have the police come and pick him up.

This way, if I had hit the button, I would not have answered the phone, that would have sent the signal to the hospital to send help.

Thank you.

[The prepared statement follows:]

## STATEMENT OF KAROLINE K. POTTER, WHEATON, MD.

My I introduce myself? I am Mrs. Karoline K. Potter. I live at 11709 Kingtree St., Weaton, Maryland 20902. I am 64 years old, a retired Federal employee having been retired for a little over two years. My last employment was with the agency NOAA for 13½ years.

I belong to the St. Luke Lutheran Church in Silver Spring, Maryland. It was through a member of the staff that I learned about Lifeline. A member of the Takoma Park Women's Club also is a member of the church who in turn informed the staff members of the advantages of Lifeline to the senior citizens of the church who are living alone and possibly may have handicap problems.

If I did not have this personal emergency response system, it would be necessary for me to be put in a nursing home. With this system, neighbors come in first and see what is needed, that often being all the help I need.

Having been stricken with polio at age 32 years, through the years there has been the gradual aging process that has taken away slowly the ability to handle all situations of life. My son married in 1967 and I have been alone since that time. I have had falls to the floor and managed to crawl to my couch in the living room. It is much harder now to do that since should I slip off the bed. Now that I have this personal emergency response service in my home I know that all I have to do is push the button and help will come. Not only will help come but the expediency of their arrival is the most important of this system. Thinking deeply how time is such an important factor when a castastrophe occurs, many many dollars are saved in emergency treatment. Just to know that should I feel a stroke coming on or having slipped out of the chair or bed to the floor, gives such peace of mind. With medical costs what they are in the emergency room (and how well do I know that after 9 ambulance rides), medicare can profit greatly by less reduction of their funds in emergency treatment.

Having the telephone company come to your house and install the jack for hookup to this personal emergency response system costing approximately $52.00 and paying $10.00 a month for use of this equipment, enabling help to come in a matter of minutes can save thousands of dollars for Medicare. How better can you treat an older person who has enjoyed the freedom of living by still remaining as independent as he or she had been for say fifty or sixty years of their lives and are now alone; I say—this can eliminate depression which is so prevalent among the people in nursing homes. I for one can speak that take away my independence and severe trouble will start. I have always been an independent person and I believe I am what I am and where I am today because of God's help to me for wanting to help myself. My friends will testify to that, one being present here who has known me since 1952. Many people in nursing homes who have to have help from medicare could possibly be living at home in an apartment by themselves if they just had this emergency response system. As one man stated in the first anniversary program of Lifeline at the Washington Adventist Hospital, it should be called Line of Life. It helps life to be maintained in the American Way. For this reason asking Medicare to pay for this minimum charge for such voluminous help this instrument gives proves to be a meager amount compared to the hundreds of thousands of dollars they can pay for being found too late, care given too late, needless nursing home expenses as well as the mental torment connected with a catastrophe.

Chairman JACOBS. Thank you all for your presentation. Three minutes, fifteen seconds, Ms. Potter. That is pretty good.

The second panel consists of the National Federation of Societies for Clinical Social Work, Inc., Marsha Wineburgh, president, accompanied by Kenneth L. Adams, Washington representative.

Also, we have the National Association for Social Workers, Mr. Burch, executive director of the Community Mental Health Center, Lawrenceburg, Ind.; the American Psychological Association and Association for the Advancement of Psychology, Dr. Eugene E. Levitt, chief, Psychology Section, Department of Psychiatry, Indiana University School of Medicine, accompanied by Clarence Martin.

I did not think that would ever end, Gene. Everybody knows who Clarence is. So if you proceed in your own fashion. Remember that one of your arguments is competition in the health care field and do not forget you have competition among yourselves for conciseness.

Forge ahead.

Mr. **Adams**. I am Ken Adams and I am the Washington representative of the National Federation of Societies for Clinical Social Work. I would like to introduce Marsha Wineburgh from New York; Ms. Wineburgh is the president of the national federation, past president of the New York State Society of Clinical Social Work Psychotherapists, and presently is on the executive council and professional board of the Post-Graduate Center for Mental Health in New York, where she is also the director of community services and education. For the last 10 years, she has been in a distinguished private practice as a clinical social worker and psychotherapist.

## STATEMENT OF MARSHA WINEBURGH, PRESIDENT, NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK, INC., ACCOMPANIED BY KENNETH L. ADAMS

Ms. **Wineburgh**. Thank you. I am pleased to have an opportunity to speak to you today. The national federation did submit a copy of my prepared testimony. I would ask that it be entered in the record.

From my experience in New York, I have been in the agencies for 20 years and in private practice for a number of years. I have supervised and trained other mental health professionals, including psychiatrists and psychologists.

I have talked with many [illegible] my colleagues in the national federation about examples of the problem that this bill is designed to alleviate.

The first person I want to [illegible] you about is a 67-year-old woman who began her problems 5 [illegible] ago when at 62, she lost her job.

She was laid off for policy [illegible] in an agency and, when laid off, she developed severe [illegible] pains.

She went to see her physician and he very conscientiously began to schedule a series [illegible] tests and GI series and hospitalizations and 4 years later, she was finally put in the position of having exploratory surgery for cancer.

All of these tests and explorations were negative. The exploratory surgery was negative. At no time did her physician suggest she have a consultation for psychiatric illness or psychosomatic illness.

Consequently, she became depressed, and he prescribed a medication for her pain, Percodan.

After 4 years, she eventually took to her bed, stopped taking care of her husband, and her children. She was now 66, her elderly mother was living with her. She became weepy, she stopped cleaning, she was essentially a wreck.

She read an article in Reader's Digest on medications and decided she was possibly addicted to Percodan. She did not call her physician. She was too embarrassed and, as many depressed people are, she blamed herself for the addiction. When she took herself off the medication, the withdrawal pushed her further into a depression and finally her physician referred her to a psychiatric specialist in geriatrics for treatment.

The psychiatrist charged $95 an hour; the recommendation was she see the psychiatrist three times a week.

She saw the woman twice, but because the family could not afford $95 a session, she stopped treatment. Feeling even more discouraged, she was referred to me because it was thought I would see her at a lower fee.

The first thing I did was send her to a psychiatrist who charged $40 a session for a medication consultation.

I saw her three times a week for 3 weeks, twice a week for 3 weeks and once a week for the next few months.

Her depression lifted, her pains disappeared after 5 years, and this woman is now a well, functioning, healthy 67-year-old president of her women's organization in her synagogue.

The reason I bring this case to your attention is because medicare paid for the exploratory operations, they paid for all her physician's bills, they paid for all of the testing.

Medicare did not pay me.

If this woman could not afford my low fee, she would not have had treatment. There are many people like her in New York who do not have the resources or cannot find private practitioners who will see them at lower fees.

My second example is a 76-year-old woman who went to see her physician because she was dizzy.

She was given medication. She continued to feel dizzy and one day fell down in her kitchen. She called her doctor, of course, and the doctor increased her medication.

A clinical social worker intervened and arranged a consultation with her and in one session, had discovered that a month before, the woman's dog, who she had had for 17 years, had died.

This may not seem like much, but the death of this dog triggered memories of a series of losses for this woman, including a son she had lost in the war, a husband, her mother and father, her brother and essentially what we have here was a woman with a conversion symptom and not a medical condition.

She was seen in short-term treatment by a clinical social worker. She was referred by the social worker to a physician who took her off the medication and within 10 sessions, the woman was functioning again.

I bring her to your attention because this is a self-sufficient 76-year-old woman. If she had fallen down and broken anything, medicare would have paid for it. Medicare would have paid for exploratory surgery for a brain tumor if this was a possibility.

But medicare does not pay the clinical social worker who saw her for 10 sessions.

That concludes my statement.

[The prepared statement follows:]

# STATEMENT BY MARSHA WINEBURGH
# ON BEHALF OF THE NATIONAL FEDERATION
# OF SOCIETIES FOR CLINICAL SOCIAL WORK

Mr. Chairman, and Members of the Subcommittee. My name is Marsha Wineburgh. I am the current president of the National Federation of Societies for Clinical Social Work, and a past president of the New York Society of Clinical Social Work Psychotherapists. I appreciate this opportunity to testify in support of H.R. 6092, which would improve the delivery of mental health services to the elderly, the disabled and the indigent by making those services available from all qualified mental health professionals, including psychiatrists, psychologists, clinical social workers, and psychiatric nurse practitioners.

I am a clinical social worker, certified by the State of New York as an independent provider of mental health services. For nearly 20 years, I have worked in New York City, serving the mental health needs of the young and old, the poor and non-poor, the white and non-white. I have worked for the Department of Social Services and the Health Insurance Plan for Greater New York. For the past ten years, I have also maintained a private practice. At present, in addition to my private practice, I am a member of the Executive Council and Professional Board, as well as the director of the Community Services and Education Division, of the Postgraduate Center for Mental Health, the largest training center in the United States which provides post-graduate training to psychiatrists, psychologists, and clinical social workers. The Postgraduate Center operates five outpatient clinics, and has a staff of approximately 200 mental health professionals, of whom less than 25% are psychiatrists.

Since it was founded in 1945, the Postgraduate Center has treated more than 35,000 patients in its outpatient clinics.

It has been my experience that the mental health delivery system around the United States has grown up around the availability of qualified mental health professionals, without regard to what kind of degree they hold. I dare say there is not a major mental health facility in the country which is staffed (or could be staffed) solely by physicians. Yet the Medicare program, which professes to provide mental health services to the elderly, will only pay for services rendered by a physician. (As I understand it, the law does not even require that the services be rendered by a trained mental health professional -- any physician will do.) In this respect, the Medicare program is an anachronism, and a cruel hoax for those Medicare and Medicaid beneficiaries who want and need help but cannot get the help they want because the available therapist of their choice is not a physician and is excluded from the financing structure.

For the purpose of this discussion, in order to simplify matters I will focus on the situation of the elderly, since I understand that this is the largest part of the Medicare population. But virtually everything I will be discussing pertains equally to the other segments of the Medicare and Medicaid populations.

There is no question about the fact that the elderly are urgently in need of additional mental health services. There is also no question about the fact that the restrictive reimbursement policy which limits payment to physicians only, is a clear impediment to improving the availability of services to the elderly. There is no question that enactment of H.R. 6092 would help the situation by making it possible for Medicare beneficiaries to obtain covered mental health services from any qualified mental health professional of their choice, without regard to the professional discipline involved. The only real question, I suspect, is whether Congress and we as a Society care enough about our parents and grandparents to attack the problem. And these days, that seems to translate into a matter of how much will it cost. Fortunately, there is every reason to believe that the cost is nominal. There is certainly no evidence that the cost would be great.

## THE MEDICARE SYSTEM DOES NOT MEET THE NEEDS OF THE PEOPLE IT IS SUPPOSED TO SERVE.

No new Congressional inquiry is needed to verify what other federal government inquiries have been finding for years. Five years ago, millions of taxpayer dollars were spent on an exhaustive study and analysis of the mental health service delivery system in the United States, with particular focus on underserved populations. The final report of the President's Commission on Mental Health warned that many older Americans "do not have sufficient access to services or to personnel trained to respond to the special needs which are characteristic of their ages." 1/ More specifically, the Commission found that although the prevalence of mental illness and emotional distress is higher among those over age sixty-five than in the general population (up to 25 percent of older persons are estimated to have significant mental health problems), only 2 percent of all patients seen in private psychiatric care are elderly.[2/] Yet that is the only kind of outpatient mental health care Medicare pays for. The National Institute of Mental Health's 1974 evaluation of aging programs in the United States found that "despite the high rates of mental disorder, treatment statistics show that the elderly receive less care than younger adults and their rate of care per 100,000 elderly population is dropping in contrast to the rising care of other adults".[3/]

Like most such studies and reports, the extensive work of the President's Commission has been essentially ignored. A recent General Accounting Office report concluded once again that the elderly still do not have adequate access to mental health services.[4/]

The bill which is now before the Subcommittee, H.R. 6092, provides Congress with an opportunity to make at least a meaningful gesture in the right direction, at little or no real cost.

## THE MEDICARE REIMBURSEMENT POLICY HAS BEEN PART OF THE PROBLEM INSTEAD OF PART OF THE SOLUTION.

By restricting outpatient mental health coverage to physicians, the Medicare program has selected the most expensive and least available segment of the mental health provider community. As the President's Commission stated, the distribution of psychiatrists is heavily weighted in favor of the urban centers and wealthier and more urbanized states. Overall, 68 percent of all counties in the United States have no psychiatrists at all. Altogether, 82 percent of psychiatrists practice in cities of 100,000 or greater. And most important, there is a relatively small number of psychiatrists who specialize in geropsychiatry. "There are only a handful of psychiatrists who specialize in psychiatric problems of the aged," according to the President's Commission.[5]

By restricting outpatient mental health coverage to physicians, Medicare is an anachronism which is twenty years behind the growth and changes in the mental health care delivery system, which today is universally recognized to consist of four "core disciplines" -- psychiatry, psychology, clinical social work, and psychiatric nursing.[6] As the President's Commission noted several years ago, psychologists, clinical social workers and psychiatric nurse practitioners provide a large percentage of mental health care, especially to the poor, to those in rural areas, and to those in community mental health centers.[7] In contrast, the relatively few psychiatrists who work in organized care systems are increasingly playing "primarily supervisory and consulting roles to other personnel who carry out the day-to-day work with patients."[8]

Under these circumstances, how does it make any sense to exclude from the Medicare delivery system the non-physician professionals who are providing the bulk of the mental health services to the poor and the elderly? According to the

President's Commission, such restrictive financing mechanisms are an aggravating factor which impedes access to quality care:

> ". . . [T]he mechanisms of financing services, particularly through insurance payments, often act as constraints on the utilization of personnel. When only physicians are reimbursed for services that can be provided by other categories of personnel then either these other categories are badly utilized or the physician may be reduced to an 'on paper' supervisor to satisfy regulations. Payment for services rendered by qualified providers, regardless of discipline, with review of quality of service, would do much to solve utilization problems."[9]

These factors led the President's Commission to make an explicit recommendation that the Medicare and Medicaid programs, as well as other existing and future publicly financed mental health service programs, should provide direct reimbursement to all independent, qualified mental health professionals, including psychiatrists, psychologists, social workers and nurses, who meet the requisite standards of education, experience and professional licensure/certification.[10] Similarly the Task Panel on Rural Mental Health, which made a series of recommendations designed to improve the availability of mental health services in rural areas, recommended that "modifications in certification requirements under Medicare and Medicaid (Titles XVIII and XIX) be instituted to allow reimbursement for outpatient, partial hospitalization and other services offered by nonphysician mental health service providers."[11] The fundamental point made by the President's Commission was that federal financing mechanisms should be based upon the appropriateness of care, not the discipline of the provider.[12]

> ". . . [R]eimbursement for services by agencies of the government or by other third party payers should be based upon the services performed and the qualifications and certification of the provider within his/her own discipline. Regulations should not favor one discipline over another when both are qualified by training and experience."[13]

It is particularly ironic, and indefensible, that at the same time Congress has allowed reimbursement only to physicians, Congress over the years has supported the training of non-physician mental health professionals in order to improve the supply of available manpower. How can it make sense for Congress to appropriate funds over the years to train clinical social workers, under such programs as the National Mental Health Act of 1946, and then to exclude from the Medicare/Medicaid delivery system the same professionals it has helped to train?

> ". . . [A] major barrier to outpatient care for populations with special needs is imposed by the public mechanisms for financing their mental health care -- Medicare and Medicaid . . . . Federal financing mechanisms have often worked at cross-purposes to federally initiated service delivery programs."[14]

And isn't it also ironic and indefensible that Congress, on the one hand, guaranteed the patient through the Medicare law "freedom of choice" in selecting a provider, and on the other hand, restricted that choice to only one class of provider -- physicians.

The President's Commission on Mental Health urged that the mental health delivery structure "guarantee" "freedom of choice" as a "basic principle" of protection for patients.[15]

Last year, Lewin and Associates, Inc. published the results of a study prepared for the Federal Trade Commission on competition among health practitioners, which examined the influence of the medical profession on the health manpower market. The study concluded that one of the principal recommended ways to give effect to broader consumer choice, and to diminish the monopoly power of physicians, was to allow the consumer the freedom to choose among: "a) providers who offer services differently; and b) a variety of health professionals . . . . If carefully designed, a system based on broadened choice could preserve professional competency while increasing competition among providers on the basis of the service they provide, quality, and price."[16/] The study warned that "unreasonable resistance to change in present manpower arrangements has, in some cases, prevented appropriate utilization of health resources and possibly raised the cost of care."[17/]

"Freedom of choice" can be a critical element in the patient's acknowledgement that he or she needs treatment, in the patient's actual resort to treatment, and in the relationship of trust and confidence in the psychotherapist necessary to make that treatment successful. The Medicare program should guarantee that eligible persons needing care for mental or nervous disorders are not denied reimbursement merely because the therapist of their choice is a clinical social worker, rather than a psychiatrist.

## MEDICARE'S RESTRICTIVE REIMBURSEMENT POLICY IS OUT OF STEP WITH THE REST OF THE INSURANCE INDUSTRY, BOTH PUBLIC AND PRIVATE.

Most major public and private health insurance plans which cover mental health services include non-physicians as well as psychiatrists as providers. In the federal sector, CHAMPUS and the Federal Employee Health Benefits Act carriers have long included non-physician mental health providers. The majority of the directors of federally funded Community Mental Health Centers around the country are social workers, not psychiatrists. In the private sector, a survey conducted by the Washington Business Group on Health found that coverage of non-physician providers is a well-established, integral part of the corporate health insurance structure.18/ A recent survey of nearly 100 private insurance companies, conducted by the National Federation of Societies for Clinical Social Work, revealed only four who did not include non-physician professionals in their outpatient mental health coverage. In sum, it is apparent that what H.R. 6092 proposes is far from novel or untried -- it is what is prevalent throughout the public and private health insurance sectors. The only excuse for maintaining the inadequacies of the status quo would be if it simply cost too much money to change it. We are convinced that is not the case, for the reasons which follow.

## THERE IS NO REASON TO BELIEVE THAT THE ENACTMENT OF H.R. 6092 WOULD SIGNIFICANTLY INCREASE THE COST OF THE MEDICARE PROGRAM.

Even if the inclusion of non-physician mental health professionals in the provider base were to increase utilization significantly, it does not necessarily follow that the overall program costs would increase proportionately. To the contrary, there is every reason to expect that increased utilization would be offset by corresponding cost savings.

For example, there is considerable evidence indicating that increased utilization of mental health services yields decreased utilization of (more expensive) doctors, hospitals and surgery. "[A]s a group, this research is most striking", the President's Commission concluded. "Research from health maintenance organizations (HMO's), from industrial programs, and from regular health insurance plans suggests that providing outpatient mental health services can reduce overall health services utilization and overall health costs. The evidence strongly suggests that the cost of including or expanding mental health coverage would be partially or wholly offset by decreasing use of general medical services."19/

One study concluded that as many as 60 percent or more of physician visits are from sufferers of emotional distress rather than organic illness.20/

The HEW Task Force which reviewed the report of the President's Commission similarly took note of the decreased cost for physical health services which could be expected to flow from increased utilization of mental health services.[21]

An article published by Jones and Vischi, of the Alcohol, Drug Abuse and Mental Health Administration, summarizes the results of twelve separate studies which have demonstrated that the cost of providing mental health services was offset by a significant decline in medical utilization.[22]

In addition, increased competition from lower cost non-physician providers would yield a lower cost per unit of treatment than the present delivery system.

The National Federation of Societies for Clinical Social Work has contacted a number of insurance carriers over the years, in an effort to collect data on the cost impact, if any, of expanding the provider base to include clinical social workers (often in response to newly enacted state laws mandating freedom-of-choice). For example, about five years ago New York State implemented a legislative requirement that clinical social workers be covered in group policies which covered psychiatric services, upon the request of the policy holder. After the first year of operation under the new mandate, not a single insurance carrier requested a rate increase to cover any anticipated or incurred additional cost. Similarly the State of California implemented a new statute in 1977 requiring group insurers to pay clinical social workers as direct providers, when their policies included coverage for psychiatrists' services. When asked what cost impact if any resulted from that requirement, Blue Shield of California advised in June 1980 that it had no data showing any cost increase, and expressed the view that "[b]ecause the coverage of psychotherapeutic services is a small part of the total health package, the expansion of allowable providers for such benefits would have little impact on the total rates for health coverage".[23/]

A large HMO in New York, the Health Insurance Plan of Greater New York, stated in a June 1981 letter that "[t]he Mental Health Service of HIP has included clinical social workers as staff members in its Mental Health Service program since the inception of the program in 1968 . . . in our system, the use of clinical social workers in providing mental health services is cost effective, and enables us to keep the cost of the mental health rider down." [24/] Similarly the American Postal Workers Union indicated that they have no data indicating any adverse cost impact flowing from the inclusion of non-physician mental health providers in their health insurance program.[25/]

The results appear to be even more positive in the case of a two year demonstration project conducted in Fiscal Years 1981 and 1982 by CHAMPUS, to measure the impact on cost and utilization of including clinical social workers as direct providers of covered mental health services. The final report has not yet been submitted, but the third interim report showed a cost saving in excess of $250,000 over the course of the two year project.

## CONCLUSION

Messrs. Carr and Sharfstein wrote an article, while at NIMH, which exploded what they termed the "five myths of mental illness", and demonstrated with appropriate data that there is simply no truth to the notions that (1) utilization and cost of treatment for mental illness are unpredictable, (2) psychiatric illness is chronic, (3) psychiatric outpatient treatment is slow and often requires years, (4) psychiatric treatment is of doubtful effectiveness, and (5) there is no agreement on diagnoses or appropriate treatments for psychiatric problems.26/ By the time this Subcommittee has completed its consideration of H.R. 6092, I hope it can be said that a sixth myth has been exploded -- namely that it is too costly to provide better mental health service to the elderly, disabled and indigent by making treatment more available. I am convinced that it is even more costly to do nothing. The human costs are enormous, as are the social costs of leaving the mental health needs of our elderly unattended. From the standpoint of just the dollars and cents involved, it has to cost more to keep paying the physician, laboratory, x-ray, surgical and hospital bills to treat the symptoms of underlying mental and emotional problems which are more effectively (and inexpensively) dealt with by a trained mental health professional -- physician or non-physician.

I hope that the extensive work of the President's Commission on Mental Health will not be ignored any longer. On behalf of the National Federation, its members, and Medicare and Medicaid beneficiaries who are unable to obtain covered mental health services from the mental health professional of their choice, I urge you to act favorably on H.R. 6092.

## References

1. The President's Commission on Mental Health, Report to the President, "Letter of Transmittal," p. vii, Vol. I, 1978.

2. Ibid., "Findings and Assessment," p. 7.

3. Ibid., "Report of the Task Panel on Mental Health of the Elderly," Vol. III, p. 1123.

4. U.S. General Accounting Office, The Elderly Remain in Need of Mental Health Service, September 16, 1982.

5. The President's Commission on Mental Health, Report to the President, "Report of the Task Panel on Mental Health Personnel," Vol. II, pp. 432-3.

6. Ibid., p. 452

7. Ibid., "Report of the Task Panel on Cost and Financing," p. 508.

8. Ibid., "Report of the Task Panel on Mental Health Personnel," p. 434.

9. Ibid., "Report of the Task Panel on Mental Health Personnel," p. 460.

10. Ibid., "Recommendations," Vol. I, p. 30.

11. Ibid., "Report of the Task Panel on Rural Mental Health," Vol. III, p. 1159.

12. Ibid., "Recommendations," Vol. I, p. 29.

13. Ibid., "Report of the Task Panel on Mental Health Personnel," Vol. II, p. 483.

14. Ibid., "Recommendations," Vol. I, p. 22.

15. The President's Commission on Mental Health, Report to the President, "Letter of Transmittal," Vol. I, p. viii, and "Findings and Assessment," p. 10.

16. Lewin and Associates, Inc., Competition Among Health Practitioners, Vol. I, p. xix.

17. Ibid., p. xv.

18. Washington Business Group on Health, Mental Wellness Programs for Employees, 1980, p. 175.

19. The President's Commission on Mental Health, Report to the President, "Report of the Task Panel on Cost and Financing," Vol. II, p. 513.

20. Ibid., "Report of the Task Panel on Mental Health of the Elderly," Vol. III, p. 1128.

21. GLS Associates, Inc., Report to National Institute of Mental Health, "Analysis of State Programs Which Mandate Mental Health Under Private Health Insurance,"June 29 1979, p. 68.

22. U.S. Department of Health, Education and Welfare, Alcohol, Drug Abuse and Mental Health Administration, Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization, by Kenneth R. Jones and Thomas R. Vischi, reprinted in Medical Care, Vol. XVII, No. 12, Supplement.

23. Walter Chan, Actuarial Department, Blue Shield of California to John B. Milnes, M.S.W., Salem, Oregon, June 3, 1980.

24. Joseph B. Collins, Administrator, Mental Health Services, Health Insurance Plan of Greater New York to Pat B. Wellons, President, Kentucky Society for Clinical Social Workers, June 23, 1981.

25. Ben Evans, Director, American Postal Workers Union, AFL-CIO to Pat B. Wellons, President, Kentucky Society for Clinical Social Work, June 24, 1981.

26. Reprinted in Washington Business Group on Health, Mental Wellness Programs for Employees, 1980, pp. 154-5.

[Subsequent to the hearing, Mr. Gradison submitted questions to Ms. Wineburgh. The responses follow:]

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## NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK, INC.

January 21, 1983

COMMITTEE ON
RECEIVED
JAN 24 1983
WAYS AND MEANS

John J. Salmon, Chief Counsel
Committee on Ways and Means
United States House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Salmon:

As a follow-up to the December 14 Health Subcommittee hearing on H.R. 6092, the following are our responses to the written questions submitted after the hearing by John Kern, Assistant Minority Counsel.

Question No. 1

> You have cited studies which indicate use of clinical social workers are cost effective since coverage would be offset by decreasing use of general medical services.
>
> I understand that the major studies in this area have come from organized prepayment settings (HMO's) where there is a financial incentive to reduce unnecessary utilization. How would you see this being translated into the non-HMO settings under fee-for-service reimbursement where there is no similar incentive and where the vast majority of patients would be treated?

Response

The President's Commission reviewed the cost effectiveness of using non-physicians as providers of mental health services and determined that the issue is two-fold:

1. Mental health problems tend to be treated in the general health care setting.

2. The treatment of mental health problems does have an effect on the utilization of general health services.

In the first instance the Commission determined that a large number of mental health problems are cared for in the general health care system. In a report by the DHEW/NIMH (Draft report 1976, p. 27) it is estimated that "60% or more of physicians' visits are made by patients who demonstrate an emotional, rather than an organic etiology for their physical symptoms." This was not limited to physician visits in organized prepaid settings.

Further, the Commission found that in those circumstances where the provider of care is not specifically trained to provide mental health services, the quality of care may be in doubt.

The second area deals with the substitution effect on general medicine. As we stated in our testimony before the Ways and Means Committee, Subcommittee on Health, on December 14, there is considerable evidence that increased utilization of mental health services decreases utilization of (more expensive) doctors, hospitals and surgery. We quoted the following conclusion of the President's Commission: "Research from health maintenance organizations (HMO's), from industrial programs, and from regular health insurance plans (fee for service plans) suggests that providing outpatient mental health services can reduce overall health services utilization and overall health costs."

You will note that the Commission research encompassed private health insurance plans based on fee-for-service reimbursement, as well as pre-payment settings (HMO's). For example, the Commission cited the Blue Cross Plan of Western Pennsylvania which compared a control group to 169 of their subscribers who used an outpatient psychotherapy benefit along with the medical/surgical benefit. They found that the subscribers who used the psychotherapy benefit were low utilizers of the medical/surgical benefit. In fact the number of outpatient visits per month for medical/surgical services decreased by more than 54%. Also, the Commission found that this reduced utilization of the medical/surgical benefit was "independent of age, sex, or employment level." 1/

In summary, research shows that increased utilization of mental health services yields decreased utilization of (more expensive) doctors, hospitals and surgery -- both in organized prepaid settings, and in fee-for-service health insurance plans.

Question No. 2

> In your written testimony you stated that increased competition from lower cost non-physician providers would yield a lower cost per unit of treatment than the present delivery system. Data from the CHAMPUS and Blue Shield of Hawaii indicate that fees for clinical psychologists have risen to the level of psychiatrists and clinical social workers' fees are rapidly approaching the same levels. In view of that experience and the experience generally with respect to medicine where increased numbers of physicians have not caused a reduction in fees, could you explain how we can expect cost savings by allowing more mental health practitioners to bill on a fee-for-service basis.

Response

To my knowledge there is nothing in the CHAMPUS data which shows that clinical social work fees are "rapidly approaching the same levels" as psychiatrists' fees. To the contrary, the recent CHAMPUS data shows that the gap between psychiatrists' fees and clinical social work fees has increased since fiscal year 1980. Attached as Appendix A is a table which shows that in 74% of the states where CHAMPUS recently obtained comparative fee data, psychiatrists' fees were 20-48% higher

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1/ The President's Commission on Mental Health, Report to the President, "Report of the Task Panel on Cost and Financing," Vol. II, pp. 512-514.

than clinical social work fees (compared with a differential of only 12% in the fiscal year 1980 data you sent us). Since there has been a great deal of misinformation about what the CHAMPUS data really shows with respect to clinical social work fees, I am also enclosing (as Appendix B) a copy of a letter sent to Sandra Casber of your committee. I believe the information is self-explanatory and needs no further clarification; however, if you have further questions please let me know.

As to the data from the Hawaii Blue Cross plan, the data appears to reflect fee differences between psychiatrists and psychologists. It does not include clinical social workers. However, as a general observation on the data, the information appears to reflect maximum allowances per case rather than charge per visit. Therefore, I do not believe this data is helpful in determining the comparison of fees for services.

Question No. 3

> To assure that fees of non-physician practitioners remain lower than those of physicians, would you support a fee schedule approach that would, for example, limit non-physician fees to the $30 per treatment hour that you charge or perhaps an amount equal to some percentage of the prevailing fee charged by physicians?

Response

We favor free competition among qualified health care providers. It is our belief that such competition will hold prices down, not force them up. As a matter of principle we also believe strongly in parity, when equally qualified providers are providing the same service. If the government wants to enforce parity at the lower prevailing fee level of clinical social workers, we would have no objection. We would object, as a matter of professional principle, to Congress making a legislative statement that an hour of psychotherapy is worth more when a physician provides it than when a clinical social worker provides it. That is simply not the case, and it seems absurd to us for Congress to insulate physicians from price competition in the manner suggested by the hypothetical question posed.

Sincerely,

Marsha Wineburgh /kcp

Marsha Wineburgh

Attachments
cc: John Kern
Sandra Casber

APPENDIX A

## TABLE 1

### COMPARISON OF PREVAILING FEES FOR PSYCHOTHERAPY SESSIONS OF 45 TO 50 MINUTES (SOURCE: CHAMPUS REPORT ON THE EXPERIMENTAL STUDY ON REIMBURSEMENT OF CLINICAL SOCIAL WORKERS (10/1/81 - 3/31/82), TABLE 5)

| STATE | PSYCHIATRIST | CLINICAL SOCIAL WORKER | PERCENTAGE DIFFERENCE |
|---|---|---|---|
| Alabama | $ 70 | $ 60 | 14% |
| Colorado | 75 | 50 | 33 |
| Georgia | 75 | 50 | 33 |
| Mississippi | 70 | * | |
| Nebraska | 70 | * | |
| Ohio | 65 | 40 | 38 |
| West Virginia | 60 | * | |
| California (North) | 75 | 50 | 33 |
| California (South) | 85 | 75 | 12 |
| Maine | 70 | 45 | 36 |
| Massachusetts | 65 | * | |
| Connecticut | 65 | * | |
| New Hampshire | 60 | 45 | 25 |
| Vermont | 60 | * | |
| Michigan | 65 | * | |
| Florida | 75 | 50 | 33 |
| Arizona | 75 | 60 | 20 |
| Nevada | 85 | * | |
| New Mexico | 68 | * | |
| Maryland | 65 | 50 | 23 |
| Delaware | 78 | 62 | 21 |
| District of Columbia | 65 | 60 | 8 |
| North Carolina | 70 | 50 | 29 |
| Pennsylvania | 60 | 40 | 33 |
| Virginia | 75 | 50 | 33 |
| South Carolina | 60 | 60 | 0 |
| Illinois | 65 | 45 | 31 |
| Iowa | 60 | 45 | 25 |
| Kentucky | 60 | 45 | 25 |

| | | | |
|---|---|---|---|
| Louisiana | 75 | 45 | 40 |
| Minnesota | 70 | 50 | 29 |
| Missouri | 60 | 50 | 17 |
| North Dakota | 80 | 42 | 48 |
| Oklahoma | 60 | 45 | 25 |
| Kansas | 65 | 50 | 23 |
| Wisconsin | 72 | 44 | 39 |
| South Dakota | 60 | 40 | 33 |
| Indiana | 65 | 50 | 23 |
| Texas | 75 | 60 | 20 |
| Arkansas | 70 | 52 | 26 |
| Tennessee | 65 | 50 | 23 |
| Rhode Island | 75 | 50 | 33 |
| New York | 75 | 55 | 27 |
| New Jersey | 75 | 55 | 27 |
| Hawaii | 88 | 80 | 9 |
| Alaska | 80 | 75 | 6 |
| Idaho | 60 | 50 | 17 |
| Montana | 60 | 50 | 17 |
| Oregon | 65 | 45 | 31 |
| Utah | 60 | 50 | 17 |
| Washington | 55 | 40 | 27 |
| Wyoming | 45 | 45 | 0 |

*Note: Indicates no clinical social worker claims were received or processed.

TABLE 2

DISTRIBUTION OF FEE DIFFERENCES BETWEEN PSYCHIATRISTS AND CLINICAL SOCIAL WORKERS

| Prevailing Fee Of Psychiatrists Is Higher By: | Number Of States | Percentage Of All States Surveyed |
|---|---|---|
| 0 - 9% | 5 | 12% |
| 10 - 19 | 6 | 14 |
| 20 - 29 | 17 | 39 |
| 30 - 39 | 13 | 30 |
| 40 - 49 | 2 | 5 |
| TOTAL: | 43 | 100% |

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**NATIONAL FEDERATION OF**
**SOCIETIES FOR CLINICAL SOCIAL WORK, INC.**

ATTACHMENT B

December 9, 1982

Ms. Sandra K. Casber
House Committee on Ways and Means
Subcommittee on Health
1104 Longworth House Office Building
Washington, D.C. 20515

Dear Sandy:

As I indicated to you in our telephone conversation, the enclosed "Third Interim Report" of the CHAMPUS experimental study on the reimbursement of clinical social workers (covering the period October 1, 1981 through March 31, 1982) clearly documents the fact that the prevailing fees of clinical social workers are significantly lower than those of psychiatrists. In Table 5, attached to the report, prevailing fees are charted for each state and region in which the demonstration project was conducted. There is not a single state or region in which the prevailing fee of psychiatrists was shown to be lower than that of clinical social workers.

The data in Table 5 corrects the misimpression which was created by the "Second Interim Report" which covered the period May 1, 1981 through September 20, 1981. The findings of that report seemed to imply that CHAMPUS had found clinical social work fees to be higher than those of psychiatrists, in the course of the demonstration project. Since that implication was contrary to every fee survey I had ever seen, I addressed a letter to Dr. John F. Beary, III at CHAMPUS on May 1, 1982, asking for clarification. A copy of my letter is enclosed. Senator Daniel K. Inouye sent a similar letter to Dr. Beary, requesting clarification. In a response to Senator Inouye dated June 23, 1982, and a response to me dated

Ms. Sandra K. Casber
December 9, 1982
Page Two

June 25, CHAMPUS apologized for "the misleading information in our report" and "the confusion which has resulted from our report". CHAMPUS explicitly advised that "our statement that 'approximately 55% of the claims were higher than amounts billed by physicians' was not accurate." (emphasis added) Copies of those letters are also enclosed for your file.

I hope this clarifies any lingering questions about the matter. The plain fact is, as Table 5 of the Third Interim Report shows, that the CHAMPUS demonstration project has once again confirmed that clinical social work fees are significantly lower than fees of psychiatrists.

If you feel it would be useful, please feel free to enclose this letter and the attachments in the record of the hearings on H.R. 6092. We look forward to presenting the testimony of the National Federation of Societies for Clinical Social Work at the hearings next week.

Sincerely,

Kenneth L. Adams

Encs.
KLA:lmc

cc: Mr. Pat DeLeon (w/ encs.)

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NATIONAL FEDERATION OF
SOCIETIES FOR CLINICAL SOCIAL WORK, INC.

May 1, 1982

John F. Beary, III, M.D.
Acting Assistant Secretary
of Defense
U.S. Department of Defense
Washington, D.C. 20301

Dear Dr. Beary:

Recently I had the opportunity to review your April 13, 1982 letter to Senator Mark Hatfield, and the accompanying "Second Interim Report" on the CHAMPUS Experimental Study on Reimbursement of Independent Certified Clinical Social Workers (May 1, 1981 through September 30, 1981). I would appreciate some clarification, and perhaps the underlying data, which would explain the basis for the following three statements in your letter and in the report:

> "Of the amounts billed for such services, approximately 55 percent of the claims were higher than the amounts billed by physicians (physician prevailing fee)."
>
> "Of the 1,280 claims received, 699 (54.9%) contained billed charges in excess of the non-specialty area prevailing charges."

> "Billed charges range from $35 to $82.50 per visit. Complete data, i.e., number, type, and length of visit(s), is not available in all cases to determine the hourly charge range."

In view of the third quote reprinted above, it is not clear to me what was compared with what, to arrive at the observations in the first two quotes. Does the study compare hourly charges by clinical social workers, for an hour of psychotherapy (individual? group? family?), with the prevailing hourly charge for similar psychotherapy rendered by a physician (presumably a psychiatrist)? If not, what was compared with what?

The findings you report in your letter to Senator Hatfield are inconsistent with virtually every previous fee comparison study I have seen, comparing hourly fees of clinical social workers, clinical psychologists, and psychiatrists, for comparable psychotherapy services.

Thank you for your assistance.

Sincerely,

Kenneth L. Adams

KLA/cch

cc: Carol P. Galaty
Director, OCHAMPUS
Washington Liaison Office
Washington, D.C. 20301

DEPARTMENT OF DEFENSE
OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
AURORA COLORADO 80045

JUN 23 1982

PDP

Honorable Daniel K. Inouye
United States Senate
Room 105, Russell Senate Building
Washington, D.C. 20510

Dear Senator Inouye:

This is in response to your May 3 letter to me regarding our "second interim report" on the CHAMPUS Experimental Study on Reimbursement of Independent Certified Clinical Social Workers. We apologize for the confusion which has resulted from our report. Our statement that "approximately 55 percent of the claims were higher than amounts billed by physicians" was not accurate.

On 55% of the claims submitted for services of clinical social workers the billed amount exceeded the allowed amount. However, the conclusion that the excess amounts resulted solely from charges greater than physician charges is wrong. Until April 1 of this year clinical social workers were reimbursed using the same profiles as those used for psychiatrists and psychologists, so any allowable charge reduction would be the result of charges exceeding those of physicians. Most of the reductions, though, were simply a result of denied services because insufficient documentation was submitted, the number of services exceeded CHAMPUS limits, or the services rendered were not covered by CHAMPUS.

I hope this has clarified the situation. Let me apologize again for the misleading information in our report.

Sincerely,

Signed

Theodore D. Wood
Director

## REPORT ON CHAMPUS EXPERIMENTAL STUDY ON REIMBURSEMENT OF CLINICAL SOCIAL WORKERS

May 1, 1981 through September 30, 1981.

A. Background. Under the FY 81 Department of Defense Appropriation Act, the Assistant Secretary of Defense for Health Affairs (ASD(HA)) was directed to conduct an experimental study of the acceptance and payment of claims for CHAMPUS-covered mental health services provided by clinical social workers independent of physician referral or supervision.

B. Study Period. The study, originally authorized from December 15, 1980 to September 30, 1981, has been extended to continue through September 30, 1982. This extension was authorized by the FY 82 Department of Defense Appropriation Act for the purpose of assuring that sufficient claim data are acquired and compiled for formulating valid study conclusions and recommendations.

C. Fee Profiles. As set forth in the study criteria, payment for services of clinical social workers is to be based on allowable charges. A charge shall be considered allowable if it does not exceed the nonspecialty area prevailing charge for the same service performed by a physician. Accordingly, the "amount allowed" as reported by the fiscal intermediaries are based on this criterion.

D. Claims Activity. Fiscal intermediaries are required to submit reports to OCHAMPUS on a scheduled basis. Table 1 summarizes data from the fiscal intermediary reports as designated. The following points summarize the report.

1. Eight of the nine fiscal intermediaries have received and processed clinical social worker claims, submitted under this study, representing 31 of the 50 states. (No report was received from Blue Cross of Southwestern Virginia. This was due to the termination of their contract on September 30, 1981. Blue Cross/Blue Shield of South Carolina was awarded the contract effective October 1, 1981. This involved the States of North Carolina, South Carolina, Virginia, and the District of Columbia.)

2. A total of 1,280 claims, representing 325 providers and 856 beneficiaries, were received.

3. Of the 1,280 claims received, 699 (54.9%) contained billed charges that were disallowed on in excess of the area prevailing allowances.

E. Progress and Trends.

1. Claim Volume. Tables 2 and 3 reflect a significant increase (350%) in the number of claims reported (1,280) from that reported for the period December 15, 1980 through April 30, 1981 (363).

a. Table 2 also shows that claims activity for two fiscal intermediaries, i.e., Blue Cross of Rhode Island and Blue Cross/Blue Shield of Tennessee, have decreased and that Wisconsin Physicians Service and Hawaii Medical Service Association, have received and processed considerably more claims than the other fiscal intermediaries.

b. Table 3 also shows there has been no claims activity for 14 states and that Hawaii and Texas, which respectively rank as first and second in volume, account for 56% of the claims.

2. High Volume Providers. Table 4 shows that the 521 claims received and processed by Wisconsin Physicians Service represent 148 providers and that the ten highest volume providers account for 205 (39.3%) of the claims, of which 122 (23%) were from the metropolitan area of San Antonio, Texas.

3. Billed Charges. Billed charges ranged from $35 to $82.50 per visit. Complete data, i.e., number, type, and length of visit(s), is not available in all cases to determine the hourly charge range.

4. Type of Care. Most of the services rendered by clinical social workers are psychotherapeutic.

5. Quality of Care. The claims are reviewed at the appropriate review points by the appropriate review levels in accordance with the procedures developed for CHAMPUS by the American Psychiatric Association. This procedure ensures that care provided by clinical social workers is reviewed in the same manner as the care provided by a physician.

Table 1

CLINICAL SOCIAL WORKER CLAIMS RECEIVED AND PROCESSED BY FISCAL INTERMEDIARY

| FISCAL INTERMEDIARY NAME | NO. OF CLAIMS--- | | | REPRESENTATIVE DATA | | |
|---|---|---|---|---|---|---|
| | RECEIVED AND PROCESSED | BILLED WITHIN LOCAL PREVAILING ALLOWANCE | BILLED IN EXCESS OF LOCAL PREVAILING ALLOWANCE | NO. OF STATES | NO. OF PROVIDERS | NO. OF BENEFICIARIES |
| CALIFORNIA, BS of | 25 | 17 | 8 | 2 | 20 | 25 |
| HAWAII MEDICAL SERVICE | 398 | 116 | 282 | 1 | 12 | 119 |
| MUTUAL OF OMAHA | 27 | 13 | 14 | 5 | 16 | 27 |
| PENNSYLVANIA, BS of | 165 | 157 | 8 | 3 | 60 | 107 |
| RHODE ISLAND, BC of | 5 | 5 | -- | 1 | 5 | 5 |
| TENNESSEE, BC-BS of | 7 | 4 | 3 | 1 | 1 | 5 |
| VIRGINIA, BC of Southwestern | -- | -- | -- | -- | -- | -- |
| WASHINGTON-ALASKA, BC of | 132 | 132 | -- | 7 | 62 | 116 |
| WISCONSIN PHYSICIAN SERVICE | 521 | 137 | 384 | 11 | 149 | 452 |
| TOTALS | 1,280 | 581 | 699 | 31 | 325 | 856 |

file - Champus

DEPARTMENT OF DEFENSE
[illegible]

PDR

Mr. Kenneth L. Adams
National Federation of Societies
for Clinical Social Workers, Inc.
2101 L. Street NW, 10th Floor
Washington DC, 20037

JUN 25 1982

Dear Mr. Adams:

This replies to your letter dated 1 May 1982 to Dr. John F. Beary, Acting Assistant Secretary of Defense for Health Affairs concerning our "second interim" report on "CHAMPUS Experimental Study on Reimbursement of Clinical Social Workers".

For your information, we are forwarding a copy of our recent letter to Senator Daniel K. Inouye (Encl 1) which also addresses your concerns. In addition, we also wish to advise that the columnar headings and statements in our report reading "billed within or in excess of physician prevailing fee" was in error and should have read "billed within or in excess of allowance". "Allowance" is defined as the amount paid by the fiscal intermediaries based on the 80th percentile of the area physician prevailing fees less any disallowed services. Corrected pages of the report reflecting these changes are also forwarded (Encl 2).

With reference to your concerns as to "range and comparison of billed charges", we wish to note that reports from our fiscal intermediaries do not contain detailed itemized information as to charges for each specific type of service/visit. Our statement that "billed charges ranged from $35 to $82.50" was merely intended as an indicator and not as a comparative to allowances.

We wish to apologize for the misleading information in our previous report and to note that it is an "interim" report. The study conclusions and recommendations will be dependent on our final report which will encompass data from all the interim reports as well as include data on cost effectiveness of clinical social workers as CHAMPUS providers.

Sincerely,

Charles [illegible]
for James N. Snipe
Chief, Policy Division

Enclosures (2)

cc:
ASDHA

552

PDR [illegible]

Mr. Kenneth L. Adams
National Federation of Societies
for Clinical Social Workers, Inc.
2102 L. Street, NW, 10th Floor
Washington, DC 20037

Dear Mr. Adams

With reference to your initial requests and subsequent correspondence and telephone calls, forwarded for your information is a copy our "third interim" report, which is the most recent, concerning our experimental study on the reimbursement of clinical social workers.

We wish to note that a "fourth interim" and final report is due from our fiscal intermediaries for the period ending 30 September 1982, which will constitute our final report on this experimental reimbursement study. A copy of this final report will be furnished to your organization as well as to the National Association of Social Workers., Inc.

Sincerely,

Thomas J. Csoba
James N. Snipe
Chief, Policy Division

Enclosure

## REPORT ON THE
## EXPERIMENTAL STUDY
## ON
## REIMBURSEMENT OF CLINICAL SOCIAL WORKERS
## October 1, 1981 through March 31, 1982

A. Background. The FY 81 Department of Defense Appropriation Act directed the Assistant Secretary of Defense for Health Affairs (ASDHA) to conduct an experimental study regarding the acceptance and payment of claims for CHAMPUS covered mental health services provided by clinical social workers independent of physician referral or supervision.

B. Study Period. The study, originally authorized from December 15, 1980 to September 30, 1981, was extended through September 30, 1982. This extension was authorized by the FY 82 Department of Defense Appropriation Act for the purpose of assuring that sufficient claims data are acquired and compiled for formulating valid study conclusions and recommendations.

C. Allowable Charges. As set forth in the study criteria, payment for services of clinical social workers is to be based on allowable charges. A charge shall be considered allowable if it does not exceed the nonspecialty area prevailing charge for the same service performed by a physician. Accordingly, the "amount billed" vs the "amount allowed" as reported by the fiscal intermediaries is applied in evaluating the claim data.

D. Claims Activity. Table 1 indicates the number of claims received and processed by fiscal intermediary. The data indicate the following:

(1) All eight fiscal intermediaries currently under contract to OCHAMPUS have received and processed clinical social worker claims representing 32 of the 50 states;

(2) A total of 1,777 claims, representing 425 providers and 947 beneficiaries were received and processed during the reporting period;

(3) Of the 1,777 claims received, 1203 (or 67.7%) contained billed charges that exceeded allowances (ie., disallowed services and/or fees).

### E. Volume and Trends.

(1) Table 2 reflects that a total of 1,777 claims were received and processed during the reporting period (October 1, 1980 through March 31, 1982). This was a 39% increase in the number of claims compared to the 1,280 claims received and processed in the previous six-month reporting period. Since the start of the study (December 15, 1980), a total of 3,420 claims have been received and processed by the fiscal intermediaries.

(2) Table 3, which reflects the number of claims received and processed by state, indicates that Hawaii continues to rank first in the number of claims with Texas as second. Of the 3,420 claims received and processed to date, Hawaii with 1,107 claims and Texas with 1,031 claims account for 62.2% of all the claims.

F. Type and Volume of Services. Table 4, which reflects the type and volume of services both by state and fiscal intermediary, indicates that 92% of the billed services are for individual psychotherapy sessions of 45 to 50 minutes.

G. Fee Profiles. Table 5 reflects the area prevailing fee profiles (by state) of clinical social workers as compared to physicians/psychiatrists based on processed claims since the start of this study. Under OCHAMPUS reimbursement principles and policies, these fees are reimbursed at the 80th percentile. Fees allowed ranged from a low of $40 in the states of Ohio, Pennsylvania and Washington to a high of $80 in Hawaii.

Cost Effectiveness. In applying the difference in fee profiles between clinical social workers and physicians for the various states as reflected in Table 5 to the number of "one-hour" sessions as reflected in Table 6, an estimated cost avoidance of over $253,000 is indicated since the inception of this study.

## Table 1

## CLINICAL SOCIAL WORKER CLAIMS RECEIVED AND PROCESSED BY FISCAL INTERMEDIARY
(Period: 1 October 1981 through 31 March 1982)

| FISCAL INTERMEDIARY | RECEIVED AND PROCESSED | NO. OF CLAIMS BILLED WITHIN PREVAILING ALLOWANCE | NO. OF CLAIMS BILLED IN EXCESS OF PREVAILING ALLOWANCE* | NO. OF STATES | REPRESENTATIVE DATA NO. OF PROVIDERS | REPRESENTATIVE DATA NO. OF BENEFICIARIES |
|---|---|---|---|---|---|---|
| CALIFORNIA, BS of | 26 | 15 | 11 | 2 | 19 | 26 |
| HAWAII MEDICAL SERVICE | 591 | 270 | 321 | 1 | 13 | 180 |
| MUTUAL OF OMAHA | 135 | 55 | 80 | 3 | 25 | 135 |
| RHODE ISLAND | 105 | 67 | 38 | 3 | 42 | 47 |
| SOUTH CAROLINA, BC-BS of | 79 | 1 | 78 | 3 | 28 | 53 |
| TENNESSEE, BC-BS of | 15 | 13 | 2 | 1 | 4 | 9 |
| WASHINGTON-ALASKA, BC of | 37 | 36 | 1 | 7 | 28 | 34 |
| WISCONSIN PHYSICIAN SERVICE | 789 | 117 | 672 | 12 | 99 | 463 |
| TOTALS | 1,777 | 574 | 1,203 | 32 | 258 | 947 |

* Includes rejected claims, disallowed services, prevailing fee reductions., etc.

TABLE 2

CLINICAL SOCIAL WORKER CLAIMS RECEIVED AND PROCESSED BY FISCAL INTERMEDIARY
(From start of experimental study (15 Dec 80) through 31 March 1982)

| Fiscal Intermediary | No. Claims 1st Interim Report (15 Dec 80 - 30 Apr 81) | No. Claims 2d Interim Report (1 May 81 - 30 Sep 81) | No. Claims 3d Interim Report (1 Oct 81 - 31 Mar 82) | Total to Date |
|---|---|---|---|---|
| CALIFORNIA, BS of | 7 | 25 | 26 | 58 |
| HAWAII MEDICAL SERVICE | 118 | 398 | 591 | 1,107 |
| MUTUAL OF OMAHA | --- | 27 | 135 | 162 |
| PENNSYLVANIA, BS of | 25 | 165 | --- | 190 |
| RHODE ISLAND, BC of | 41 | 5 | 105 | 151 |
| SOUTH CAROLINA, BC-BS of | --- | --- | 79* | 79 |
| TENNESSEE, BC-BS of | 15 | 7 | 15 | 37 |
| VIRGINIA, BC-BS of Southwest | 98 | (no report) | --- | 98 |
| WASHINGTON-ALASKA, BC of | 15 | 132 | 37 | 184 |
| WISCONSIN PHYSICIAN SERVICE | 44 | 521 | 789 | 1,354 |
| TOTALS | 363 | 1,280 | 1,777 | 3,420 |
| % Increase | --- | 352% | 39% | --- |

*Note: Includes previous fiscal intermediaries, BS of Pennsylvania and BC BS of Southwest Virginia.

TABLE 3

CLINICAL SOCIAL WORKER CLAIMS BY STATE
AS RECEIVED AND PROCESSED BY FISCAL INTERMEDIARIES
(From start of study (15 Dec 80) through 31 March 1982)

| FI CODE* | | STATE | No. Claims 1st Interim Report (15 Dec 80 - 30 Apr 81) | No. Claims 2d Interim Report (1 May 81 - 30 Sep 81) | No. Claims 3d Interim Report (1 Oct 81 - 31 Mar 82) | Total to Date |
|---|---|---|---|---|---|---|
| C | 1 | Alabama | --- | 3 | --- | 3 |
| H | 2 | Alaska | --- | 13 | 2 | 15 |
| A | 3 | Arizona | --- | --- | | --- |
| I | 4 | Arkansas | 8 | 24 | 58 | 90 |
| A | 5 | California | 7 | 24 | 24 | 55 |
| C | 6 | Colorado | --- | 8 | 77 | 85 |
| A | 7 | Connecticut | --- | --- | --- | --- |
| DS | 8 | Delaware | --- | 1 | --- | 1 |
| GS | 9 | District of Columbia | 17 | --- | --- | 17 |
| A | 10 | Florida | ---- | --- | 2 | 2 |
| C | 11 | Georgia | --- | 8 | 44 | 52 |
| B | 12 | Hawaii | 118 | 398 | 591 | 1,107 |
| H | 13 | Idaho | --- | 7 | 4 | 11 |
| I | 14 | Illinois | 7 | 11 | 31 | 49 |
| I | 15 | Indiana | --- | 3 | 3 | 6 |
| I | 16 | Iowa | --- | 2 | --- | 2 |
| I | 17 | Kansas | 3 | 12 | 9 | 24 |
| I | 18 | Kentucky | 2 | 9 | 7 | 18 |
| I | 19 | Louisiana | --- | 43 | 23 | 66 |
| A | 20 | Maine | --- | 1 | --- | 1 |
| DS | 21 | Maryland | 25 | 162 | 65 | 252 |
| A | 22 | Massachusetts | --- | --- | --- | ---- |
| A | 23 | Michigan | --- | --- | --- | --- |
| I | 24 | Minnesota | 3 | --- | 1 | 4 |
| C | 25 | Mississippi | --- | --- | --- | --- |

TABLE 3 (continued)

| FI CODE* | | STATE | No. Claims 1st Interim Report (15 Dec 80 - 30 Apr 81) | No. Claims 2d Interim Report (1 May 81 - 30 Sep 81) | No. Claims 3d Interim Report (1 Oct 81 - 31 Mar 82) | Total to Date |
|---|---|---|---|---|---|---|
| I | 26 | Missouri | 11 | 12 | 10 | 3 |
| H | 27 | Montana | 1 | 22 | 9 | 3 |
| C | 28 | Nebraska | --- | --- | --- | -- |
| A | 29 | Nevada | --- | --- | --- | -- |
| A | 30 | New Hampshire | --- | --- | --- | -- |
| E | 31 | New Jersey | 17 | --- | 9 | 2 |
| A | 32 | New Mexico | --- | --- | --- | -- |
| E | 33 | New York | 24 | 5 | 89 | 11 |
| GS | 34 | North Carolina | 4 | --- | 2 | |
| I | 35 | North Dakota | 1 | 4 | --- | |
| C | 36 | Ohio | --- | 6 | 14 | 2 |
| I | 37 | Oklahoma | 5 | 10 | 6 | 2 |
| H | 38 | Oregon | --- | 9 | 5 | 1 |
| DS | 39 | Pennsylvania | --- | 2 | --- | |
| E | 40 | Rhode Island | --- | --- | 7 | |
| GS | 41 | South Carolina | 17 | --- | --- | 1 |
| I | 42 | South Dakota | --- | --- | 1 | |
| F | 43 | Tennessee | 15 | 7 | 15 | 3 |
| I | 44 | Texas | --- | 393 | 638 | 1,03 |
| H | 45 | Utah | 3 | 11 | 1 | 1 |
| A | 46 | Vermont | --- | --- | --- | -- |
| GS | 47 | Virginia | 60 | --- | 12 | 7 |
| H | 48 | Washington | 12 | 64 | 16 | 9 |
| C | 49 | West Virginia | --- | --- | --- | -- |
| I | 50 | Wisconsin | 3 | --- | --- | |
| H | 51 | Wyoming | --- | 6 | 2 | |
| | | TOTALS | 363 | 1,280 | 1,777 | 3,42 |

*FI Codes:

| | | | |
|---|---|---|---|
| A | California, BS of | F | Tennessee |
| B | Hawaii Medical Service | G | Virginia |
| C | Mutual of Omaha | H | Washington-Alaska, BC of |
| D | Pennsylvania, BS of | I | Wisconsin Physician Service |
| E | Rhode Island, BC of | S | South Carolina, BC-BS of |

## TABLE 4

## TYPE AND VOLUME OF PSYCHOTHERAPY SERVICES

| FISCAL INTERMEDIARY AND STATE | "A" INDIVIDUAL 60 MINUTE | "B" INDIVIDUAL 30 MINUTE | "C" GROUP THERAPY | "D" FAMILY THERAPY | "E" PSYCHOLOGIC TESTING |
|---|---|---|---|---|---|
| CALIFORNIA, BS of | | | | | |
| California (South) | 312 | 3 | 3 | 15 | --- |
| California (North) | 25 | --- | --- | --- | --- |
| Florida | --- | --- | --- | --- | --- |
| RHODE ISLAND, BC of | | | | | |
| New Jersey | 68 | --- | --- | --- | --- |
| New York | 264 | 58 | --- | --- | --- |
| Rhode Island | 11 | --- | --- | --- | --- |
| SOUTH CAROLINA, BC-BS of | | | | | |
| Maryland | 549 | 2 | --- | --- | --- |
| North Carolina | 8 | --- | --- | --- | --- |
| Virginia | 71 | --- | --- | --- | --- |
| TENNESSEE BC-BS of | | | | | |
| Tennessee | 63 | --- | 15 | --- | --- |
| WASHINGTON-ALASKA, BC of | | | | | |
| Alaska | 10 | --- | --- | --- | --- |
| Idaho | 10 | --- | --- | --- | --- |
| Montana | 32 | --- | --- | --- | --- |
| Oregon | 22 | --- | --- | --- | --- |
| Utah | 4 | --- | --- | --- | --- |
| Washington | 79 | --- | --- | --- | --- |
| Wyoming | 17 | 1 | --- | --- | --- |

TABLE 4 (continued)

| FISCAL INTERMEDIARY AND STATE | "A" INDIVIDUAL 60 MINUTE | "B" INDIVIDUAL 30 MINUTE | "C" GROUP THERAPY | "D" FAMILY THERAPY | "E" PSYCHOLOGIC TESTING |
|---|---|---|---|---|---|
| HAWAII MEDICAL SERVICE | | | | | |
| Hawaii | 1396 | --- | --- | --- | --- |
| MUTUAL OF OMAHA | | | | | |
| Colorado | 577 | --- | --- | --- | --- |
| Georgia | 222 | --- | --- | --- | --- |
| Ohio | 216 | --- | --- | --- | --- |
| WISCONSIN PHYSICIAN SERVICE | | | | | |
| Arkansas | 76 | --- | 17 | --- | --- |
| Illinois | 142 | 14 | --- | 4 | --- |
| Indiana | 21 | --- | --- | --- | --- |
| Kansas | 39 | 6 | --- | --- | --- |
| Kentucky | 21 | 6 | --- | 23 | --- |
| Louisiana | 69 | 1 | --- | 57 | --- |
| Minnesota | 4 | --- | 6 | --- | --- |
| Missouri | 41 | 1 | 2 | 4 | --- |
| Oklahoma | 38 | --- | --- | --- | --- |
| South Dakota | 1 | --- | --- | --- | --- |
| Texas | 2667 | 48 | 260 | 63 | 58 |
| TOTALS | 7207 | 140 | 303 | 166 | 56 |
| % of Total | (91.5%) | (01.8%) | (03.8%) | (02.1%) | (0.6%) |

## TABLE 5

## COMPARATIVE PREVAILING FEE PROFILES
for
PSYCHOTHERAPY SESSIONS OF 45 TO 50 MINUTES
(As of 1 April 1982)

| State | Physician (Psychiatrist) | Clinical Social Worker |
|---|---|---|
| MUTUAL OF OMAHA | | |
| Alabama | $70 | $60 |
| Colorado | 75 | 50 |
| Georgia | 75 | 50 |
| Mississippi | 70 | * |
| Nebraska | 70 | * |
| Ohio | 65 | 40 |
| West Virginia | 60 | * |
| BLUE SHIELD OF CALIFORNIA | | |
| California (North) | 75 | 50 |
| California (South) | 85 | 75 |
| Maine | 70 | 45 |
| Massachusetts | 65 | * |
| Connecticut | 65 | * |
| New Hampshire | 60 | 45 |
| Vermont | 60 | * |
| Michigan | 65 | * |
| Florida | 75 | 50 |
| Arizona | 75 | 60 |
| Nevada | 85 | * |
| New Mexico | 68 | * |

TABLE 5 (continued)

| State | Physician (Psychiatrist) | Clinical Social Worker |
|---|---|---|
| BLUE CROSS OF SOUTH CAROLINA | | |
| Maryland | $65 | $50 |
| Delaware | 78 | 62 |
| District of Columbia | 65 | 60 |
| North Carolina | 70 | 50 |
| Pennsylvania | 60 | 40 |
| Virginia | 75 | 50 |
| South Carolina | 60 | 60 |
| WISCONSIN PHYSICIAN SERVICE | | |
| Illinois | $65 | $45 |
| Iowa | 60 | 45 |
| Kentucky | 60 | 45 |
| Louisiana | 75 | 45 |
| Minnesota | 70 | 50 |
| Missouri | 60 | 50 |
| North Dakota | 80 | 42 |
| Oklahoma | 60 | 45 |
| Kansas | 65 | 50 |
| Wisconsin | 72 | 44 |
| South Dakota | 60 | 40 |
| Indiana | 65 | 50 |
| Texas | 75 | 60 |
| Arkansas | 70 | 52 |

TABLE 5 (continued)

| State | Physician (Psychiatrist) | Clinical Social Worker |
|---|---|---|
| BlUF-CROSS-BLUE SHIELD OF TENNESSEE | | |
| Tennessee | 65 | 50 |
| BLUE CROSS OF RHODE ISLAND | | |
| Rhode Island | 75 | 50 |
| New York | 75 | 55 |
| New Jersey | 75 | 55 |
| HAWAII MEDICAL SERVICE ASSOCIATION | | |
| Hawaii | 88 | 80 |
| BLUE CROSS OF WASHINGTON-ALASKA | | |
| Alaska | 80 | 75 |
| Idaho | 60 | 50 |
| Montana | 60 | 50 |
| Oregon | 65 | 45 |
| Utah | 60 | 50 |
| Washington | 55 | 40 |
| Wyoming | 45 | 45 |

*Note: Indicates no clinical social worker claims were received or processed.

## TABLE 6

## CLINICAL SOCIAL WORKER SERVICES
(INDIVIDUAL ONE HOUR VISITS/SESSIONS)

| FI | STATE | | NUMBER OF VISITS<br>1ST REPORT | <br>2ND REPORT | <br>3RD REPORT | TOTAL VISITS | COST AVOIDANCE PER FEE | TOTAL COST AVOIDANCE* |
|---|---|---|---|---|---|---|---|---|
| C | 1 | Alabama | --- | 28 | --- | 28 | $10 | $ 280 |
| H | 2 | Alaska | --- | 98 | 10 | 108 | 5 | 540 |
| A | 3 | Arizona | --- | --- | --- | --- | --- | --- |
| I | 4 | Arkansas | 17 | 173 | 76 | 266 | 18 | 4,788 |
| A | 5 | California (North) | 10 | 41 | 25 | 76 | 25 | 1,900 |
| A | 5 | California (South) | 40 | 196 | 312 | 548 | 10 | 5,480 |
| C | 6 | Colorado | --- | 31 | 577 | 608 | 25 | 15,200 |
| A | 7 | Connecticut | --- | --- | --- | --- | --- | --- |
| DS | 8 | Delaware | --- | 6 | --- | 6 | 16 | 96 |
| GS | 9 | District of Columbia | 129 | --- | --- | 129 | 5 | 645 |
| A | 10 | Florida | --- | --- | 32 | 32 | 25 | 800 |
| C• | 11 | Georgia | --- | 22 | 222 | 244 | 25 | 6,100 |
| B | 12 | Hawaii | 321 | 1,089 | 1,396 | 2,806 | 8 | 22,448 |
| H | 13 | Idaho | --- | 28 | 10 | 38 | 10 | 380 |
| I | 14 | Illinois | 7 | 112 | 142 | 261 | 20 | 5,220 |
| I | 15 | Indiana | --- | 5 | 21 | 26 | 15 | 390 |
| I | 16 | Iowa | --- | 14 | --- | 14 | 15 | 210 |
| I | 17 | Kansas | 3 | 82 | 39 | 124 | 15 | 1,860 |
| I | 18 | Kentucky | 2 | 35 | 21 | 58 | 15 | 870 |
| I | 19 | Louisiana | --- | 426 | 69 | 495 | 30 | 14,850 |
| A | 20 | Maine | --- | 9 | --- | 9 | 25 | 225 |
| DS | 21 | Maryland | 163 | 1,038 | 549 | 1,750 | 15 | 26,250 |
| A | 22 | Massachusetts | --- | --- | --- | --- | --- | --- |
| A | 23 | Michigan | --- | --- | --- | --- | --- | --- |
| I | 24 | Minnesota | 3 | --- | 4 | 7 | 20 | 140 |
| C | 25. | Mississippi | --- | --- | --- | --- | --- | --- |
| I | 26 | Missouri | 10 | 87 | 41 | 138 | 10 | 1,380 |

* The difference between the prevailing physician fee and the allowed Social Worker fee

TABLE 6 (continued)

| FI CODE | | STATE | NUMBER OF VISITS 1ST REPORT | 2ND REPORT | 3D REPORT | TOTAL VISITS | COST AVOIDANCE PER FEE | TOTAL COST AVOIDANCE |
|---|---|---|---|---|---|---|---|---|
| H | 27 | Montana | 17 | 75 | 22 | 114 | 10 | 1,140 |
| C | 28 | Nebraska | --- | --- | --- | --- | --- | --- |
| A | 29 | Nevada | --- | --- | --- | --- | --- | --- |
| A | 30 | New Hampshire | --- | --- | --- | --- | --- | --- |
| E | 31 | New Jersey | 85 | --- | 68 | 153 | 20 | 3,060 |
| A | 32 | New Mexico | --- | --- | --- | --- | --- | --- |
| E | 33 | New York | 137 | 27 | 264 | 428 | 20 | 8,530 |
| GS | 34 | North Carolina | 20 | --- | 9 | 28 | 20 | 560 |
| I | 35 | North Dakota | 1 | 36 | --- | 37 | 38 | 1,406 |
| C | 36 | Ohio | --- | 29 | 216 | 245 | 25 | 6,125 |
| I | 37 | Oklahoma | 5 | 26 | 38 | 69 | 15 | 1,035 |
| H | 38 | Oregon | --- | 36 | 22 | 58 | 20 | 1,160 |
| DS | 39 | Pennsylvania | --- | 21 | --- | 21 | 20 | 420 |
| E | 40 | Rhode Island | --- | --- | 11 | 11 | 25 | 275 |
| GS | 41 | South Carolina | 58 | --- | --- | 58 | 0 | --- |
| I | 42 | South Dakota | --- | --- | 1 | 1 | 20 | 20 |
| F | 43 | Tennessee | 43 | 13 | 63 | 119 | 15 | 1,785 |
| I | 44 | Texas | --- | 3,839 | 2,667 | 6,504 | 15 | 97,560 |
| H | 45 | Utah | 19 | 34 | 4 | 57 | 10 | 570 |
| A | 46 | Vermont | --- | --- | --- | --- | --- | --- |
| GS | 47 | Virginia | 308 | --- | 71 | 379 | 25 | 9,495 |
| H | 48 | Washington | 280 | 345 | 79 | 704 | 15 | 10,560 |
| C | 49 | West Virginia | --- | --- | --- | --- | --- | --- |
| I | 50 | Wisconsin | 3 | --- | --- | 3 | 28 | 84 |
| H | 51 | Wyoming | --- | 18 | 17 | 35 | 0 | --- |

TOTAL COST AVOIDANCE.............................................................. $253,837

Key, FI Codes:

| | | | |
|---|---|---|---|
| A | California, BS of | F | Tennessee, BC-BS of |
| B | Hawaii Medical Service | G | Virginia, BC of Southwest |
| C | Mutual of Omaha | H | Washington, Alaska, BC of |
| D | Pennsylvania, BS of | I | Wisconsin Physician Service |
| E | Rhode Island, BC of | S | South Carolina, BC-BS of |

Chairman JACOBS. Thank you.

Would you go next?

Mr. MARTIN. I think the social workers have another witness.

Chairman JACOBS. Fine, proceed.

## STATEMENT OF LARRY L. BURCH, ACSW, EXECUTIVE DIRECTOR, COMMUNITY MENTAL HEALTH CENTER, INC., LAWRENCEBURG, IND., ON BEHALF OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.

Mr. BURCH. I am Larry Burch, executive director of the Community Mental Health Center in Lawrenceburg, Ind.

I am an active member of the National Association of Social Workers. I am a native Hoosier who spent the last 12 years of his professional life working in the community mental health care system in Indiana.

In my particular center, we employ about equal numbers of social workers, psychologists, and nurses, approximately 14 each, and we employ 2 full-time psychiatrists.

I am in a position to not only observe daily, but to participate in the multidisciplinary approach that takes place in a community mental health center.

I might add that it is my feeling that each of the four professions has a unique contribution to make in the mental health field.

There are areas of overlap, areas of service that can be provided equally well by each of the four groups. There are other services uniquely the domain of the other professional group. I think we need to recognize that.

Today, however, I am here not representing my own center, but I am here on behalf of NASW, and I want to congratulate Hon. Andrew Jacobs, Jr., chairman, and the members of the Subcommittee on Health for your demonstration of leadership in this effort to provide effective care and treatment for those of our senior citizens who are in need of mental health treatment.

In terms of competing for the valuable dollar, I will dispense with reading the rest of my text and would like to turn to the statement of summary found in the back of the document

In summary, we support the enactment of the provisions of H.R. 6092 to amend titles 18 and 19 of the Social Security Act for the following reasons.

One, present restrictions of the Social Security Act and medicare regulations pertaining to mental health treatment services and providers cannot be justified in light of current knowledge.

In fact, each of the four mental health professions has a unique contribution to make in the mental health field and in some areas of practice, they are uniquely qualified to provide certain elements of care.

Two, the needs of the aged population groups have been well-documented by the President's Commission on Mental Health; in 1978, hearings of the Select Committee on Aged; White House Conference on Aged; the Mini-Conference on Mental Health of Older Americans, and others.

I think particularly in the President's Commission, the word "underserved" was used for the aging population.

In some areas of the country, it may not just be underserved, it may be not served at all. Part of the reason for that is that we find that older citizens do not always use traditional modes of treatment in that they are fearful of coming into an office setting to get help.

Sometimes you must—at least on initial contacts—reach out to them. If you sit in your office and expect the person with mental health needs in the elderly population to come to you, you are probably fooling yourself and that population group will not get care.

Three, studies conducted by the National Institute of Mental Health have established the fact that social workers constitute the largest group of professionals providing treatment in community mental health centers and other studies have expanded this recognition to most other organized treatment facilities.

Four, every major insurance carrier writing health insurance either issues or has available policies which recognize clinical social workers as independent providers of mental health treatment.

Five, although there has been much rhetoric about the issue, no one has come forth with documentation that the expansion of recognition to nonphysician professional treatment workers such as clinical social workers, psychologists or psychiatric nurses has significantly increased the cost of mental health insurance coverage.

Six, an experimental—recent study by CHAMPUS endorsed the quality and cost-effectiveness of clinical social work as a treatment resource.

Eight, access is certainly a key factor in receipt of mental health treatment services for the aged. The issue has been addressed before, not only must providers be in the geographic area, but they must be willing sometimes to do some nontraditional things.

Social work, because of its normal distribution in cities, suburban communities, and rural areas, still offers the greater potential for effectively meeting the mental health needs of the aged.

In summary, we wholeheartedly support the recognition of all four major mental health providers identified in H.R. 6092.

Thank you.

[The prepared statement and additional material follow:]

## STATEMENT OF LARRY L. BURCH, ACSW, EXECUTIVE DIRECTOR, COMMUNITY MENTAL HEALTH CENTER, INC., ON BEHALF OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

Mr. Chairman, members of the Subcommittee on Health, my name is Larry Burch. I am the Executive Director of the Lawrenceburg Indiana Community Mental Health Center, Inc. and an active member of the National Association of Social Workers (NASW). On behalf of NASW I want to congratulate the Honorable Andrew Jacobs, Jr., Chair and members of the Subcommittee on Health for your exertion of leadership in this struggle to provide effective care and treatment for those of our senior citizens who are in need of mental health treatment services at a time in their lives when both opportunity and economic resources are likely to have dwindled to a slow trickle. I know that we do not need to remind you of the aged who have risked their lives on the battlefields of the world in order to protect and keep America safe, the aged whose bodies tilled the soil and manned the factories and whose minds educated our young and opened up the secrets of the universe for our use, the aged whose tax dollars during their productive years financed the growth of our country. But, there are those who have either forgotten or give little thought to the contributions of these senior citizens who may be in serious need of our help.

H.R. 6092 introduced by the Honorable Floyd Fithian of Indiana is a much appreciated effort to ensure that mentally ill persons amongst the aged population will have accessability to the most appropriate mental health treatment services that are available to treat their individual conditions regardless of their geographic place of residence. NASW urges the members of the Subcommittee to take favorable action to correct what was obviously an oversight by the Congress when Title XVIII of the Social Security Act was enacted into law. We believe that the time has come to correct this serious error.

The purpose of this legislation is simple and clear: the full recognition of the present day delivery systems role of the major, non-physician, core mental health provider under the Medicaid and Medicare (Part B) program. In so doing, the proposed legislation can be said to make several statements:

1. A continuation of the medical model only reimbursement policy is not sufficiently responsive to the treatment needs of the mentally ill in this country.
2. The impact of the inclusion of the core mental health provider on use of services has not been determined to increase costs.
3. Competition among service providers, not privilege or monopoly, is more likely to produce cost-effective services to the targeted populations.
4. The data available shows few or minimal federal programs or state administration obstacles to implementing recognition of non-physician provider.
5. Quality assurance of mental health services can be provided by the professional associations in conjunction with government.

Simply, discrimination against non-physician mental health providers cannot be excused on social or economic grounds.

During the past fifteen years numerous studies have addressed the delivery of mental health treatment services to the aged population in the United States. The 1978 Report of the President's Commission on Mental Health identified the aged as one of the nation's underserved population groups. It also recommended recognition of the four mental health professions of psychiatric nursing, psychiatry, clinical psychology, and clinical social work as reimbursable autonomous mental health treatment providers.

In November 1980 The American Nurses Association, the American Psychiatric Association, the American Psychological Association and the National Association of Social Work held a mini-invitational conference on meeting the mental health needs of the aged. One hundred and twenty knowledgeable persons in work with the aged including physicians, attorneys, nurses, social workers, psychologists, congressional staffers and research scientists discussed the issues for three days. Amongst their recommendations was the amendment of Titles XVIII and XIX of the Social Security Act to extend recognition of providers to include the four major mental health professional providers for purposes of reimbursement. The recommendations from Congressional Hearings, the 1981 White House Conference on Aging and other studies and conferences have echoed this theme.

The remainder of my testimony will focus primarily on the merits for recognition of the clinical social worker as an independently reimbursable mental health professional. I would like to make it clear that the National Association of Social Workers strongly supports the recognition of each of the four major mental health professions as independent treatment providers. We present the case for clinical social work because that is the area of our greatest expertise.

The knowledge, skill and ability of clinical social workers to provide effective treatment for many forms of mental illness is no longer a debatable issue. During the past twenty years clinical social workers have emerged numerically as the largest single group of professionals providing mental health treatment in our nations inpatient treatment facilities, and community based outpatient treatment facilities.

The 1978 National Institute of Mental Health study on federally funded community mental health centers entitled "Community Mental Health Centers: the Federal Investment" clearly established that social workers were the largest single group of professionals providing mental health treatment in community mental health centers. This has also been documented by NASW surveys of public and private programs providing mental health treatment. NASW represents more than 90,000 professionally trained social workers primarily located in the United States. We estimate that two-fifths or 36,000 could meet the definition of clinical social worker as it is defined in H.R. 6092. It is also our best estimate that no more than 3,000 of this number are in full-time private practice leaving 33,000 employed in agencies and institutions operated under public and private auspices. While growing numbers of social workers are working with the aged any concern about unleashing large masses of professionals on the aged and on the federal treasury must be tempered by the fact that few clinical social workers working in private practice or outpatient services specialize in working with the aged. Because of the widespread distribution of clinical social workers in cities, suburbs and rural areas, social work still offers the greatest potential professional resource for meeting the mental health treatment needs of the aged.

At the present time twenty-two states license or certify clinical social workers at the independent clinical practice level. Ten states (see attachment) have enacted laws that mandate insurance company recognition of clinical social workers as reimbursable mental health providers. Every insurance carrier specializing in writing health insurance issues policies that recognize clinical social workers as treatment providers. In spite of the hue and cry that is often made about the dangers of expanding mental health provider recognition no insurance company has come forth with evidence to support this scare tactic. Our inquiries of insurance companies has always resulted in statements to the effect that the mental health claims are such an insignificant portion of their business that they do not identify the volume by provider groups. (see attached letter from Blue Shield of California). The efforts of the New York State Insurance Commission in seeking to identify the cost of adding clinical social workers to the list of reimbursable providers was not met by the cooperation from the insurance industry. In fact there have been no requests for rate increases in four years. (see attached)

Studies on the effectiveness of mental health treatment have been conducted by many concerned investigators. For the most part they have indicated that the outcome of the most commonly used treatment method, psychotherapy, is comparable when provided by anyone of the four major mental health professionals. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) has recently completed a twenty-one month study on the reimbursement of clinical social workers as independent providers. The preliminary reports covering fifteen and a half months and 3,420 cases indicate that treatment has been comparable to that which would have been provided by a physician. It also indicates a cost avoidance of $253,000. Psychotherapy Finances of Ridgewood N.J. conducts periodic surveys of fees charged by mental health professionals in private practice. These surveys indicate that the median fee for clinical social workers is $40–$50 per treatment hour. This is approximately $25 per hour lower than the median fee for psychiatrists. The HCFA has awarded a contract to the Stanford Research Institute for the design of a Medicare Clinical Social Work Demonstration Project mandated by the Congress in 1980. This should be operable in 1983.

In June 1982 social workers were serving as commissioners of mental health in nine states and the District of Columbia. Except for the fact that many states have laws which restrict the position of commissioner to physicians, we believe that more social workers would be the top public official responsible for their states delivery of mental health services.

The social work profession is concerned about the quality of care delivered by its member practitioners. Consequently NASW has established standards and internal mechanisms for hearing complaints and taking disciplinary actions against members judged guilty of violating the ethics and standards of the profession. We are currently in the process of developing a nationally coordinated peer review system that will be available to any public or private insurance program. We anticipate that this program will be operable in 1983 and that it will complement the existing peer review programs operated by the American Psychological Association and the American Psychiatric Association.

In this brief presentation I have tried to share with you brief pieces of information relative to the role of clinical social workers in the delivery of mental health services in our nation. We have provided staff of the Subcommittee with more detailed information. It is our opinion that all of the available evidence recognizes the need of the aged for far greater access to mental health treatment services. We believe that the evidence also strongly supports the need to recognize all four major mental health provider groups as reimbursable providers under Title XVIII of the Social Security Act as the most cost effective method for addressing the situation. We hope that members of the Subcommittee on Health and the Congress will agree with these opinions and make H.R. 6092 a part of the Medicare law.

I thank you for the opportunity to share with you. If any of the members of the Subcommittee have a question I would be pleased to respond.

## SUMMARY STATEMENT

NASW supports the enactment of the provisions of H.R. 6092 to amend Titles XVIII and XIX of the Social Security Act for the following reasons:

1. The present restrictions of the Social Security Act and the medicare regulations pertaining to mental health treatment services and providers cannot be justified in the light of current knowledge.

2. The needs of the aged population groups have been well documented by the President's Commission on Mental Health, 1978; Hearings of the Select Committee on the Aged; the White House Conferences on the Aged; the Mini-Conference on the Mental Health of Older Americans and others.

3. Studies conducted by the National Institute of Mental Health have established the fact that social workers constitute the largest group of professionals providing treatment in community mental health centers. Other studies expand this recognition to all organized treatment facilities.

4. Every major insurance carrier writing health insurance does issue insurance policies which recognize clinical social worders as independent providers of mental health treatment.

5. No one has come forth with documentation that the expansion of recognition to non-medical professional treatment providers such as clinical social workers, clinical psychologists or psychiatric nurses has significantly increased the cost of mental health insurance coverage.

6. An experimental study by CHAMPUS endorsed the quality and the cost-effectiveness of clinical social work treatment.

7. Nine states and the District of Columbia's departments of mental health were headed by a social worker as of June 1982.

8. Accessibility is an important factor in the receipt of mental health treatment services by the Aged. Social work because of its normal distribution in cities, suburban communities and rural areas still offers the greatest potential for effectively meeting the mental health needs of the aged.

9. We support the recognition of the four major mental health providers identified in H.R. 6092.

DEPARTMENT OF DEFENSE
OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
AURORA COLORADO 80045

PDR

SEP 2 1982

Mr. James M. Evans, Jr.
Senior Staff Associate
National Association of Social Workers, Inc.,
1425 H Street, NW, Suite 600
Washington, DC 20005

Dear Mr. Evans:

With reference to your initial requests and subsequent correspondence and telephone calls, forwarded for your information is a copy our "third interim" report, which is the most recent, concerning our experimental study on the reimbursement of clinical social workers.

We wish to note that a "fourth interim" and final report is due from our fiscal intermediaries for the period ending 30 September 1982, which will constitute our final report on this experimental reimbursement study. A copy of this final report will be furnished to your organization as well as to the National Federation of Societies for Clinical Social Workers.

Sincerely,

Thomas J. Coba
for James N. Snipe
Chief, Policy Division

Enclosure

# REPORT ON THE
# EXPERIMENTAL STUDY
# ON
# REIMBURSEMENT OF CLINICAL SOCIAL WORKERS
October 1, 1981 through March 31, 1982

A. Background. The FY 81 Department of Defense Appropriation Act directed the Assistant Secretary of Defense for Health Affairs (ASDHA) to conduct an experimental study regarding the acceptance and payment of claims for CHAMPUS covered mental health services provided by clinical social workers independent of physician referral or supervision.

B. Study Period. The study, originally authorized from December 15, 1980 to September 30, 1981, was extended through September 30, 1982. This extension was authorized by the FY 82 Department of Defense Appropriation Act for the purpose of assuring that sufficient claims data are acquired and compiled for formulating valid study conclusions and recommendations.

C. Allowable Charges. As set forth in the study criteria, payment for services of clinical social workers is to be based on allowable charges. A charge shall be considered allowable if it does not exceed the nonspecialty area prevailing charge for the same service performed by a physician. Accordingly, the "amount billed" vs the "amount allowed" as reported by the fiscal intermediaries is applied in evaluating the claim data.

D. Claims Activity. Table 1 indicates the number of claims received and processed by fiscal intermediary. The data indicate the following:

(1) All eight fiscal intermediaries currently under contract to OCHAMPUS have received and processed clinical social worker claims representing 32 of the 50 states;

(2) A total of 1,777 claims, representing 425 providers and 947 beneficiaries were received and processed during the reporting period;

(3) Of the 1,777 claims received, 1203 (or 67.7%) contained billed charges that exceeded allowances (ie., disallowed services and/or fees).

E. Volume and Trends.

(1) Table 2 reflects that a total of 1,777 claims were received and processed during the reporting period (October 1, 1980 through March 31, 1982). This was a 39% increase in the number of claims compared to the 1,280 claims received and processed in the previous six-month reporting period. Since the start of the study (December 15, 1980), a total of 3,420 claims have been received and processed by the fiscal intermediaries.

(2) Table 3, which reflects the number of claims received and processed by state, indicates that Hawaii continues to rank first in the number of claims with Texas as second. Of the 3,420 claims received and processed to date, Hawaii with 1,107 claims and Texas with 1,031 claims account for 62.2% of all the claims.

F. Type and Volume of Services. Table 4, which reflects the type and volume of services both by state and fiscal intermediary, indicates that 92% of the billed services are for individual psychotherapy sessions of 45 to 50 minutes.

G. Fee Profiles. Table 5 reflects the area prevailing fee profiles (by state) of clinical social workers as compared to physicians/psychiatrists based on processed claims since the start of this study. Under OCHAMPUS reimbursement principles and policies, these fees are reimbursed at the 80th percentile. Fees allowed ranged from a low of $40 in the states of Ohio, Pennsylvania and Washington to a high of $80 in Hawaii.

Cost Effectiveness. In applying the difference in fee profiles between clinical social workers and physicians for the various states as reflected in Table 5 to the number of "one-hour" sessions as reflected in Table 6, an estimated cost avoidance of over $253,000 is indicated since the inception of this study.

## Table 1

## CLINICAL SOCIAL WORKER CLAIMS RECEIVED AND PROCESSED BY FISCAL INTERMEDIARY
(Period: 1 October 1981 through 31 March 1982)

| | NO. OF CLAIMS | | | REPRESENTATIVE DATA | | |
|---|---|---|---|---|---|---|
| FISCAL INTERMEDIARY | RECEIVED AND PROCESSED | BILLED WITHIN PREVAILING ALLOWANCE | BILLED IN EXCESS OF PREVAILING ALLOWANCE* | NO. OF STATES | NO. OF PROVIDERS | NO. OF BENEFICIARIES |
| CALIFORNIA, BS of | 26 | 15 | 11 | 2 | 19 | 26 |
| HAWAII MEDICAL SERVICE | 591 | 270 | 321 | 1 | 13 | 180 |
| MUTUAL OF OMAHA | 135 | 55 | 80 | 3 | 25 | 135 |
| RHODE ISLAND | 105 | 67 | 38 | 3 | 42 | 47 |
| SOUTH CAROLINA, BC-BS of | 79 | 1 | 78 | 3 | 28 | 53 |
| TENNESSEE, BC-BS of | 15 | 13 | 2 | 1 | 4 | 9 |
| WASHINGTON-ALASKA, BC of | 37 | 36 | 1 | 7 | 28 | 34 |
| WISCONSIN PHYSICIAN SERVICE * | 789 | 117 | 672 | 12 | 99 | 463 |
| TOTALS | 1,777 | 574 | 1,203 | 32 | 258 | 947 |

* Includes rejected claims, disallowed services, prevailing fee reductions., etc.

## TABLE 2

### CLINICAL SOCIAL WORKER CLAIMS RECEIVED AND PROCESSED BY FISCAL INTERMEDIARY
(From start of experimental study (15 Dec 80) through 31 March 1982)

| Fiscal Intermediary | No. Claims 1st Interim Report (15 Dec 80 - 30 Apr 81) | No. Claims 2d Interim Report (1 May 81 - 30 Sep 81) | No. Claims 3d Interim Report (1 Oct 81 - 31 Mar 82) | Total to Date |
|---|---|---|---|---|
| CALIFORNIA, BS of | 7 | 25 | 26 | 58 |
| HAWAII MEDICAL SERVICE | 118 | 398 | 591 | 1,107 |
| MUTUAL OF OMAHA | --- | 27 | 135 | 162 |
| PENNSYLVANIA, BS of | 25 | 165 | --- | 190 |
| RHODE ISLAND, BC of | 41 | 5 | 105 | 151 |
| SOUTH CAROLINA, BC-BS of | --- | --- | 79* | 79 |
| TENNESSEE, BC-BS of | 15 | 7 | 15 | 37 |
| VIRGINIA, BC-BS of Southwest | 98 | (no report) | --- | 98 |
| WASHINGTON-ALASKA, BC of | 15 | 132 | 37 | 184 |
| WISCONSIN PHYSICIAN SERVICE | 44 | 521 | 789 | 1,354 |
| TOTALS | 363 | 1,280 | 1,777 | 3,420 |
| % Increase | --- | 352% | 39% | --- |

*Note: Includes previous fiscal intermediaries, BS of Pennsylvania and BC BS of Southwest Virginia.

## TABLE 3

### CLINICAL SOCIAL WORKER CLAIMS BY STATE
### AS RECEIVED AND PROCESSED BY FISCAL INTERMEDIARIES
(From start of study (15 Dec 80) through 31 March 1982)

| FI CODE* | | STATE | No. Claims 1st Interim Report (15 Dec 80 - 30 Apr 81) | No. Claims 2d Interim Report (1 May 81 - 30 Sep 81) | No. Claims 3d Interim Report (1 Oct 81 - 31 Mar 82) | Total to Date |
|---|---|---|---|---|---|---|
| C | 1 | Alabama | --- | 3 | --- | 3 |
| H | 2 | Alaska | --- | 13 | 2 | 15 |
| A | 3 | Arizona | --- | --- | | --- |
| I | 4 | Arkansas | 8 | 24 | 58 | 90 |
| A | 5 | California | 7 | 24 | 24 | 55 |
| C | 6 | Colorado | --- | 8 | 77 | 85 |
| A | 7 | Connecticut | --- | --- | --- | --- |
| DS | 8 | Delaware | --- | 1 | --- | 1 |
| GS | 9 | District of Columbia | 17 | --- | --- | 17 |
| A | 10 | Florida | ---- | --- | 2 | 2 |
| C | 11 | Georgia | --- | 8 | 44 | 52 |
| B | 12 | Hawaii | 118 | 398 | 591 | 1,107 |
| H | 13 | Idaho | --- | 7 | 4 | 11 |
| I | 14 | Illinois | 7 | 11 | 31 | 49 |
| I | 15 | Indiana | --- | 3 | 3 | 6 |
| I | 16 | Iowa | --- | 2 | --- | 2 |
| I | 17 | Kansas | 3 | 12 | 9 | 24 |
| I | 18 | Kentucky | 2 | 9 | 7 | 18 |
| I | 19 | Louisiana | --- | 43 | 23 | 66 |
| A | 20 | Maine | --- | 1 | --- | 1 |
| DS | 21 | Maryland | 25 | 162 | 65 | 252 |
| A | 22 | Massachusetts | --- | --- | --- | ---- |
| A | 23 | Michigan | --- | --- | --- | --- |
| I | 24 | Minnesota | 3 | --- | 1 | 4 |
| C | 25 | Mississippi | --- | --- | --- | --- |

TABLE 3 (continued)

| FI CODE* | | STATE | No. Claims 1st Interim Report (15 Dec 80 - 30 Apr 81) | No. Claims 2d Interim Report (1 May 81 - 30 Sep 81) | No. Claims 3d Interim Report (1 Oct 81 - 31 Mar 82) | Total to Date |
|---|---|---|---|---|---|---|
| I | 26 | Missouri | 11 | 12 | 10 | 33 |
| H | 27 | Montana | 1 | 22 | 9 | 32 |
| C | 28 | Nebraska | --- | --- | --- | --- |
| A | 29 | Nevada | --- | --- | --- | --- |
| A | 30 | New Hampshire | --- | --- | --- | --- |
| E | 31 | New Jersey | 17 | --- | 9 | 26 |
| A | 32 | New Mexico | --- | --- | --- | --- |
| E | 33 | New York | 24 | 5 | 89 | 118 |
| GS | 34 | North Carolina | 4 | --- | 2 | 6 |
| I | 35 | North Dakota | 1 | 4 | --- | 5 |
| C | 36 | Ohio | --- | 6 | 14 | 20 |
| I | 37 | Oklahoma | 5 | 10 | 6 | 21 |
| H | 38 | Oregon | --- | 9 | 5 | 14 |
| DS | 39 | Pennsylvania | --- | 2 | --- | 2 |
| E | 40 | Rhode Island | --- | --- | 7 | 7 |
| GS | 41 | South Carolina | 17 | --- | --- | 17 |
| I | 42 | South Dakota | --- | --- | 1 | 1 |
| F | 43 | Tennessee | 15 | 7 | 15 | 37 |
| I | 44 | Texas | --- | 393 | 638 | 1,031 |
| H | 45 | Utah | 3 | 11 | 1 | 15 |
| A | 46 | Vermont | --- | --- | --- | --- |
| GS | 47 | Virginia | 60 | --- | 12 | 72 |
| H | 48 | Washington | 12 | 64 | 16 | 92 |
| C | 49 | West Virginia | --- | --- | --- | --- |
| I | 50 | Wisconsin | 3 | --- | --- | 3 |
| H | 51 | Wyoming | --- | 6 | 2 | 8 |
| | | TOTALS | 363 | 1,280 | 1,777 | 3,420 |

*FI Codes:

| | | | |
|---|---|---|---|
| A | California, BS of | F | Tehnessee |
| B | Hawaii Medical Service | G | Virginia |
| C | Mutual of Omaha | H | Washington-Alaska, BC of |
| D | Pennsylvania, BS of | I | Wisconsin Physician Service |
| E | Rhode Island, BC of | S | South Carolina, BC-BS of |

## TABLE 4

## TYPE AND VOLUME OF PSYCHOTHERAPY SERVICES

| FISCAL INTERMEDIARY AND STATE | "A" INDIVIDUAL 60 MINUTE | "B" INDIVIDUAL 30 MINUTE | "C" GROUP THERAPY | "D" FAMILY THERAPY | "E" PSYCHOLOGIC TESTING |
|---|---|---|---|---|---|
| CALIFORNIA, BS of | | | | | |
| California (South) | 312 | 3 | 3 | 15 | --- |
| California (North) | 25 | --- | --- | --- | --- |
| Florida | --- | --- | --- | --- | --- |
| RHODE ISLAND, BC of | | | | | |
| New Jersey | 68 | --- | --- | --- | --- |
| New York | 264 | 58 | --- | --- | --- |
| Rhode Island | 11 | --- | --- | --- | --- |
| SOUTH CAROLINA, BC-BS of | | | | | |
| Maryland | 549 | 2 | --- | --- | --- |
| North Carolina | 8 | --- | --- | --- | --- |
| Virginia | 71 | --- | --- | --- | --- |
| TENNESSEE BC-BS of | | | | | |
| Tennessee | 63 | --- | 15 | --- | --- |
| WASHINGTON-ALASKA, BC of | | | | | |
| Alaska | 10 | --- | --- | --- | --- |
| Idaho | 10 | --- | --- | --- | --- |
| Montana | 22 | --- | --- | --- | --- |
| Oregon | 22 | --- | --- | --- | --- |
| Utah | 4 | --- | --- | --- | --- |
| Washington | 79 | --- | --- | --- | --- |
| Wyoming | 17 | 1 | --- | --- | --- |

TABLE 4 (continued)

| FISCAL INTERMEDIARY AND STATE | "A" INDIVIDUAL 60 MINUTE | "B" INDIVIDUAL 30 MINUTE | "C" GROUP THERAPY | "D" FAMILY THERAPY | "E" PSYCHOLOGIC TESTING |
|---|---|---|---|---|---|
| HAWAII MEDICAL SERVICE | | | | | |
| Hawaii | 1396 | --- | --- | --- | --- |
| MUTUAL OF OMAHA | | | | | |
| Colorado | 577 | --- | --- | --- | --- |
| Georgia | 222 | --- | --- | --- | --- |
| Ohio | 216 | --- | --- | --- | --- |
| WISCONSIN PHYSICIAN SERVICE | | | | | |
| Arkansas | 76 | --- | 17 | --- | --- |
| Illinois | 142 | 14 | --- | 4 | --- |
| Indiana | 21 | --- | --- | --- | --- |
| Kansas | 39 | 6 | --- | --- | --- |
| Kentucky | 21 | 6 | --- | 23 | --- |
| Louisiana | 69 | 1 | --- | 57 | --- |
| Minnesota | 4 | --- | 6 | --- | --- |
| Missouri | 41 | 1 | 2 | 4 | --- |
| Oklahoma | 38 | --- | --- | --- | --- |
| South Dakota | 1 | --- | --- | --- | --- |
| Texas | 2667 | 48 | 260 | 63 | 58 |
| TOTALS | 7207 | 140 | 303 | 166 | 58 |
| % of Total | (91.5%) | (01.8%) | (03.8%) | (02.1%) | (0.6%) |

## TABLE 5

## COMPARATIVE PREVAILING FEE PROFILES
for
PSYCHOTHERAPY SESSIONS OF 45 TO 50 MINUTES
(As of 1 April 1982)

| State | Physician (Psychiatrist) | Clinical Social Worker |
|---|---|---|
| **MUTUAL OF OMAHA** | | |
| Alabama | $70 | $60 |
| Colorado | 75 | 50 |
| Georgia | 75 | 50 |
| Mississippi | 70 | * |
| Nebraska | 70 | * |
| Ohio | 65 | 40 |
| West Virginia | 60 | * |
| **BLUE SHIELD OF CALIFORNIA** | | |
| California (North) | 75 | 50 |
| California (South) | 85 | 75 |
| Maine | 70 | 45 |
| Massachusetts | 65 | * |
| Connecticut | 65 | * |
| New Hampshire | 60 | 45 |
| Vermont | 60 | * |
| Michigan | 65 | * |
| Florida | 75 | 50 |
| Arizona | 75 | 60 |
| Nevada | 85 | * |
| New Mexico | 68 | * |

TABLE 5 (continued)

| State | Physician (Psychiatrist) | Clinical Social Worker |
|---|---|---|
| | BLUE CROSS OF SOUTH CAROLINA | |
| Maryland | $65 | $50 |
| Delaware | 78 | 62 |
| District of Columbia | 65 | 60 |
| North Carolina | 70 | 50 |
| Pennsylvania | 60 | 40 |
| Virginia | 75 | 50 |
| South Carolina | 60 | 60 |
| | WISCONSIN PHYSICIAN SERVICE | |
| Illinois | $65 | $45 |
| Iowa | 60 | 45 |
| Kentucky | 60 | 45 |
| Louisiana | 75 | 45 |
| Minnesota | 70 | 50 |
| Missouri | 60 | 50 |
| North Dakota | 80 | 42 |
| Oklahoma | 60 | 45 |
| Kansas | 65 | 50 |
| Wisconsin | 72 | 44 |
| South Dakota | 60 | 40 |
| Indiana | 65 | 50 |
| Texas | 75 | 60 |
| Arkansas | 70 | 52 |

TABLE 5 (continued)

| State | Physician (Psychiatrist) | Clinical Social Worker |
|---|---|---|
| | BlUE-CROSS-BLUE SHIELD OF TENNESSEE | |
| Tennessee | 65 | 50 |
| | BLUE CROSS OF RHODE ISLAND | |
| Rhode Island | 75 | 50 |
| New York | 75 | 55 |
| New Jersey | 75 | 55 |
| | HAWAII MEDICAL SERVICE ASSOCIATION | |
| Hawaii | 88 | 80 |
| | BLUE CROSS OF WASHINGTON-ALASKA | |
| Alaska | 80 | 75 |
| Idaho | 60 | 50 |
| Montana | 60 | 50 |
| Oregon | 65 | 45 |
| Utah | 60 | 50 |
| Washington | 55 | 40 |
| Wyoming | 45 | 45 |

*Note: Indicates no clinical social worker claims were received or processed.

TABLE 6

CLINICAL SOCIAL WORKER SERVICES
(INDIVIDUAL ONE HOUR VISITS/SESSIONS)

| PI | | STATE | NUMBER OF VISITS | | | TOTAL VISITS | COST AVOIDANCE PER FEE | TOTAL COST AVOIDANCE* |
|---|---|---|---|---|---|---|---|---|
| | | | 1ST REPORT | 2ND REPORT | 3RD REPORT | | | |
| C | 1 | Alabama | --- | 28 | --- | 28 | $10 | $ 280 |
| H | 2 | Alaska | --- | 98 | 10 | 108 | 5 | 540 |
| A | 3 | Arizona | --- | --- | --- | --- | --- | --- |
| I | 4 | Arkansas | 17 | 173 | 76 | 266 | 18 | 4,788 |
| A | 5 | California (North) | 10 | 41 | 25 | 76 | 25 | 1,900 |
| A | 5 | California (South) | 40 | 196 | 312 | 548 | 10 | 5,480 |
| C | 6 | Colorado | --- | 31 | 577 | 608 | 25 | 15,200 |
| A | 7 | Connecticut | --- | --- | --- | --- | --- | --- |
| DS | 8 | Delaware | --- | 6 | --- | 6 | 16 | 96 |
| GS | 9 | District of Columbia | 129 | --- | --- | 129 | 5 | 645 |
| A | 10 | Florida | --- | --- | 32 | 32 | 25 | 800 |
| C | 11 | Georgia | --- | 22 | 222 | 244 | 25 | 6,100 |
| B | 12 | Hawaii | 321 | 1,089 | 1,396 | 2,806 | 8 | 22,448 |
| H | 13 | Idaho | --- | 28 | 10 | 38 | 10 | 380 |
| I | 14 | Illinois | 7 | 112 | 142 | 261 | 20 | 5,220 |
| I | 15 | Indiana | --- | 5 | 21 | 26 | 15 | 390 |
| I | 16 | Iowa | --- | 14 | --- | 14 | 15 | 210 |
| I | 17 | Kansas | 3 | 82 | 39 | 124 | 15 | 1,860 |
| I | 18 | Kentucky | 2 | 35 | 21 | 58 | 15 | 870 |
| I | 19 | Louisiana | --- | 426 | 69 | 495 | 30 | 14,850 |
| A | 20 | Maine | --- | 9 | --- | 9 | 25 | 225 |
| DS | 21 | Maryland | 163 | 1,038 | 549 | 1,750 | 15 | 26,250 |
| A | 22 | Massachusetts | --- | --- | --- | --- | --- | --- |
| A | 23 | Michigan | --- | --- | --- | --- | --- | --- |
| I | 24 | Minnesota | 3 | --- | 4 | 7 | 20 | 140 |
| C | 25 | Mississippi | --- | --- | --- | --- | --- | --- |
| I | 26 | Missouri | 10 | 87 | 41 | 138 | 10 | 1,380 |

* The difference between the prevailing physician fee and the allowed social worker fee.

TABLE 6 (continued)

| FI CODE | | STATE | NUMBER OF VISITS 1ST REPORT | 2ND REPORT | 3D REPORT | TOTAL VISITS | COST AVOIDANCE PER FEE | TOTAL COST AVOIDANCE |
|---|---|---|---|---|---|---|---|---|
| H | 27 | Montana | 17 | 75 | 22 | 114 | 10 | 1,140 |
| C | 28 | Nebraska | --- | --- | --- | --- | --- | --- |
| A | 29 | Nevada | --- | --- | --- | --- | --- | --- |
| A | 30 | New Hampshire | --- | --- | --- | --- | --- | --- |
| E | 31 | New Jersey | 85 | --- | 68 | 153 | 20 | 3,060 |
| A | 32 | New Mexico | --- | --- | --- | --- | --- | --- |
| E | 33 | New York | 137 | 27 | 264 | 428 | 20 | 8,530 |
| GS | 34 | North Carolina | 20 | --- | 9 | 28 | 20 | 560 |
| I | 35 | North Dakota | 1 | 36 | --- | 37 | 38 | 1,406 |
| C | 36 | Ohio | --- | 29 | 216 | 245 | 25 | 6,125 |
| I | 37 | Oklahoma | 5 | 26 | 38 | 69 | 15 | 1,035 |
| H | 38 | Oregon | --- | 36 | 22 | 58 | 20 | 1,160 |
| DS | 39 | Pennsylvania | --- | 21 | --- | 21 | 20 | 420 |
| E | 40 | Rhode Island | --- | --- | 11 | 11 | 25 | 275 |
| GS | 41 | South Carolina | 58 | --- | --- | 58 | 0 | --- |
| I | 42 | South Dakota | --- | --- | 1 | 1 | 20 | 20 |
| F | 43 | Tennessee | 43 | 13 | 63 | 119 | 15 | 1,785 |
| I | 44 | Texas | --- | 3,839 | 2,667 | 6,504 | 15 | 97,560 |
| H | 45 | Utah | 19 | 34 | 4 | 57 | 10 | 570 |
| A | 46 | Vermont | --- | --- | --- | --- | --- | --- |
| GS | 47 | Virginia | 308 | --- | 71 | 379 | 25 | 9,495 |
| H | 48 | Washington | 280 | 345 | 79 | 704 | 15 | 10,560 |
| C | 49 | West Virginia | --- | --- | --- | --- | --- | --- |
| I | 50 | Wisconsin | 3 | --- | --- | 3 | 28 | 84 |
| H | 51 | Wyoming | --- | 18 | 17 | 35 | 0 | --- |

TOTAL COST AVOIDANCE........................................................ $253,837

Key, FI Codes:

A California, BS of
B Hawaii Medical Service
C Mutual of Omaha
D Pennsylvania, BS of
E Rhode Island, BC of

F Tennessee, BC-BS of
G Virginia, BC of Southwest
H Washington, Alaska, BC of
I Wisconsin Physician Service
S South Carolina, BC-BS of

555

**STATE OF NEW YORK**
**INSURANCE DEPARTMENT**
AGENCY BUILDING ONE
THE GOVERNOR NELSON A. ROCKEFELLER
EMPIRE STATE PLAZA
ALBANY, NEW YORK 12257

JAMES W. CLYNE
DEPUTY SUPERINTENDENT

October 8, 1980

Mr. Fred Newdom, ACSW
Executive Director
New York State Chapter
National Association of Social
  Workers, Inc.
225 Lark Street
Albany, New York 12210

Dear Mr. Newdom:

In your letter of September 17, 1980 you request premium and rate information relating to coverage for mental and nervous disorders where there has been an option to make payments to certified social workers.

The Insurance Department did conduct a study and requested information from both commercial insurers and Article IX-C corporations. We have had limited data sent to us by insurers relating to social worker coverage. You will note from the enclosures that almost all insurers either have no experience to report, or in the case of psychiatric coverage, have failed to separate the premium and claims experience for the psychiatric coverage. We do, however, have experience data from Buffalo Blue Shield and two group plans where there is substantial psychiatric coverage.

If I can be of further assistance, please let me know.

Very truly yours,

James W. Clyne
Deputy Superintendent

JWC/dg
Enclosures

## ARTICLE IX-C CORPORATIONS

Results of Survey Requesting Policyholder Data and
Premium and Claims Experience for Contracts and
Riders Written Pursuant to Chapters 893 and 894 of
the Laws of 1977.

### PSYCHIATRIC RIDER COVERAGE
### AS OF DECEMBER 31, 1979

| | Income | Claims | Number of Persons Covered | % of All Contract |
|---|---|---|---|---|
| lbany BC | 12,250 | -0- | 1,339 | 4.07 |
| BS | 15,947 | 7,250 | | |
| uffalo BC | 14,902 | (7) | 878 | .30 |
| BS (1) | 966 | N/A | 487 | .20 |
| ew York BC | 81,557 | 14,814 | 15,407 | .41 |
| Experience Rated | (6) | -- | 965 | .02 |
| ew York BS (2)(3) | 48,176 | N/A | 15,342 | .68 |
| Experience Rated | (6) | N/A | 2,675 | .15 |
| ochester BC | -0- | -0- | -0- | -0- |
| BS | -0- | -0- | -0- | -0- |
| yracuse BC | 4,001 | (7) | 490 | .10 |
| BS | 2,497 | | 490 | .10 |
| tica BC | -0- | -0- | -0- | -0- |
| BS (4) | -0- | -0- | -0- | -0- |
| atertown BC (5) | -0- | -0- | 17,508 | 100.0 |
| HI | 710,000 | 593,000 | 112,000 | 8.60 |
| MO's | (6) | (7) | (8) | 100.0 (8 |
| TOTAL | 890,296 | 615,064 | 167,581 | |

1) For experience data see attached Exhibit 1.
2) Plan's non-statutory riders are in some respects better than statutory and in other respect have lesser than statutory benefits.
3) For experience data see attached Exhibits 2 and 3.
4) Health Service, Inc. major medical contracts extensive in Utica area, provide comprehensive level of treatment and care for psychiatric.
5) Statutory benefits made part of basic coverage -- 17,508 policyholders with the statutory coverage.
6) Premium cannot be broken out.
7) Claims disbursed through regular basic contract.
8) Statutory benefits made part of basic coverage -- 247,171 policyholders.

[illegible]

## BLUE SHIELD OF WESTERN NEW YORK, INC.
## UTILIZATION OF PSYCHIATRIC SERVICES

As part of a cost containment report by Blue Shield of Western New York, Inc., an analysis was made of benefits provided under contracts providing in-office medical-surgical benefits. That portion of the report setting forth data concerning the psychiatric benefit follows:

> This analysis shows that of all office procedures covered under Blue Shield, the Psychiatric benefit generates 36.5% of the dollars paid and 22.9% of the services. To bring this down to dollars, the average payment per office service (excluding Psychiatric) was $23.00 in 1979, the average Psychiatric Office payment was $45.00 -- almost twice the cost. This is significant when you take into consideration we are addressing one particular type of medical service as compared to all other services covered under the Blue Shield program.
>
> The following is the complete statistical background for 1979 used to compute these figures:
>
> | | Services | % to Total | Dollars | % to Total |
> |---|---|---|---|---|
> | Total Incurred (excluding Radiology) | 844,300 | | $43,715,000 | |
> | Total Office Procedures | 299,000 | 35.4 | 8,344,000 | 19.1 |
> | Psychiatric Services (hospital & Office) | 77,300 | 9.2 | 3,458,000 | 7.9 |
>
> | | | |
> |---|---|---|
> | Psychiatric Office Procedures | — | 68,500 |
> | Total Incurred Payment | -- | $3,045,000 |
> | Percent Office Psychiatric Visits to Total Psychiatric Visits | -- | 89% |
> | Percent Office Psychiatric Payments to Total Psychiatric Payments | -- | 88.1% |
>
> | | Services | % to Total | Dollars | % to Total |
> |---|---|---|---|---|
> | Percent of Psychiatric Office to Total Office Procedures | | 22.9 | | 36.5 |
>
> | | |
> |---|---|
> | Average Psychiatric Office Payment | -- $45 per service |
> | Average Office Procedure Payment (excluding Psychiatric) | -- $23 per service |
> | Average Office Procedure Payment (including Psychiatric) | -- $28 per service |
>
> Exhibit 1-A shows the utilization of Psychiatric services per 1,000 contracts which indicates a leveling off for the past three years. However, our Cost Containment efforts could be impacted with increased usage of a service which is extremely difficult to control.

[illegible] Psychiatric Care
Services per M/ottends

EXHIBIT 1-A

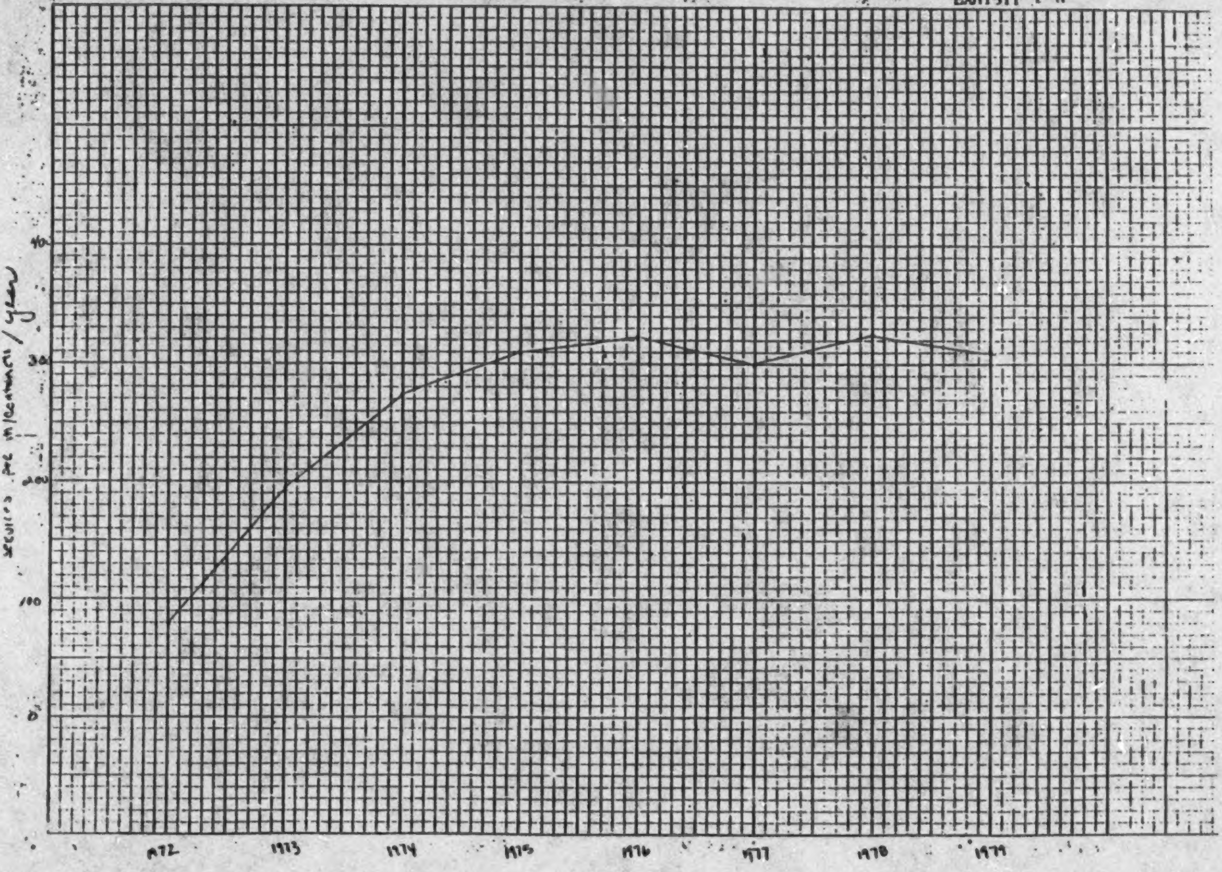


EXHIBIT 2

## Blue Cross and Blue Shield

## ANALYSIS OF SUBSCRIBERS RECEIVING NERVOUS AND MENTAL BENEFITS 1970 THROUGH 1979

| | Number of Subscribers Receiving Any Kind of a Benefit | | Number of Subscribers Receiving a Nervous and Mental Benefit | | | |
|---|---|---|---|---|---|---|
| ear | Number | % of Covered Population | Number | % of Subscribers Rec. any Benefit | % of Cov. Population | Average Benefits Paid Per Subscriber Receiving Nervous and Mental Benefits |
| 970 | 1,919,536 | 38% | 44,625 | 2.3% | .9% | $ 936.74 |
| 971 | 2,044,805 | 40% | 48,206 | 2.4% | .9% | $1,033.20 |
| 972 | 2,128,250 | 42% | 52,404 | 2.5% | 1.0% | $1,040.27 |
| 973 | 2,289,731 | 43% | 59,500[1] | 2.6% | 1.1% | $1,037.04 |
| 975[2] | 2,732,971 | 46% | 68,529 | 2.5% | 1.2% | $1,324.65 |
| 976 | 2,761,270 | 48% | 77,291 | 2.8% | 1.4% | $1,403.01 |
| 977 | 2,647,138 | 48% | 82,501 | 3.1% | 1.5% | $1,411.48 |
| 978 | 2,548,913 | 47% | 86,807 | 3.4% | 1.6% | $1,423.30 |
| 979 | 2,560,829 | 48% | 89,200 | 3.5% | 1.7% | $1,532.97 |

/ Estimated
/ 1974 data has not been produced

/5/80

Blue Cross and Blue Shield

## NUMBER OF OUTPATIENT PSYCHOTHERAPY VISITS PER 1000 CONTRACTS BY TYPE OF PROVIDER, 1974-1979

| | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 | Percent Increase 1974 to 19 |
|---|---|---|---|---|---|---|---|
| **ychiatrist** | | | | | | | |
| Outpatient Visits Per 1000 Contracts | 436.9 | 505.0 | 542.0 | 547.7 | 569.0 | 562.5 | |
| Percent Increase Over Previous Year | — | 15.6% | 7.3% | 0.9% | 3.9% | (1.1%) | 28.8% |
| **Non-Medical Therapist*** | | | | | | | |
| Outpatient Visits Per 1000 Contracts | 84.0 | 142.2 | 193.2 | 237.4 | 244.4 | 264.4 | |
| Percent Increase Over Previous Year | — | 69.3% | 35.9% | 22.9% | 2.9% | 8.2% | 214.8% |
| **Clinical Psychologist** | | | | | | | |
| Outpatient Visits Per 1000 Contracts | — | — | 95.6 | 141.1 | 155.3 | 174.5 | |
| Percent Increase Over Previous Year | — | — | — | 47.6% | 10.0% | 12.4% | — |
| **Total Providers** | | | | | | | |
| Outpatient Visits Per 1000 Contracts | 520.9 | 647.2 | 735.2 | 785.1 | 813.4 | 826.9 | |
| Percent Increase Over Previous Year | — | 24.2% | 13.6% | 6.8% | 3.6% | 1.7% | 58.7% |
| **Non-Medical Therapists as a Percent of Total** | 16.1% | 22.0% | 26.3% | 30.2% | 30.0% | 32.0% | |

*Includes clinical psychologists, psychiatric social workers, and psychiatric nurses

/5/80

Blue Cross and Blue Shield

## AVERAGE COST PER OUTPATIENT PSYCHOTHERAPY VISIT BY TYPE OF PROVIDER, 1974-1979

| | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 | Percent Increase 1974 to 197 |
|---|---|---|---|---|---|---|---|
| ychiatrist | | | | | | | |
| Average Cost Per Visit | $30.66 | $33.95 | $37.11 | $39.03 | $41.52 | $44.40 | |
| Percent Increase Over Previous Year | — | 10.7% | 9.3% | 5.2% | 6.4% | 6.9% | 44.8% |
| n-Medical Therapist* | | | | | | | |
| Average Cost Per Visit | $26.51 | $29.58 | $31.63 | $33.11 | $34.96 | $37.52 | |
| Percent Increase Over Previous Year | — | 11.6% | 6.9% | 4.7% | 5.6% | 7.3% | 41.5% |
| Clinical Psychologist | | | | | | | |
| Average Cost Per Visit | — | — | $34.45 | $36.76 | $38.36 | $40.95 | |
| Percent Increase Over Previous Year | — | — | — | 6.7% | 4.4% | 6.8% | — |
| tal Providers | | | | | | | |
| Average Cost Per Visit | $30.00 | $32.99 | $35.68 | $37.24 | $39.55 | $42.21 | |
| Percent Increase Over Previous Year | — | 10.0% | 8.2% | 4.4% | 6.2% | 6.7% | 40.7% |

ncludes clinical psychologists, psychiatric social workers, and psychiatric nurses

/80

[illegible] by Option and by Type of Service, [illegible]

| | 1964 | 1965 | 1966 | 1967 | 1968 | 1969 | 1970 | 1971 |
|---|---|---|---|---|---|---|---|---|
| **HIGH OPTION** | | | | | | | | |
| (1) Psychiatric | $ 9,429,375.25 | $ 13,441,229.04 | $ 13,069,071.90 | $ 17,960,794.79 | $ 24,465,527.26 | $ 29,837,289.74 | $ 40,362,047.97 | $ 47,952,727.4 |
| (2) All Other | 200,360,586.60 | 271,849,470.88 | 248,292,655.16 | 301,480,081.44 | 359,056,752.64 | 424,500,350.14 | 530,019,680.77 | 612,257,593.5 |
| (3) Total | 209,789,961.85 | 285,290,699.92 | 261,361,727.06 | 319,440,876.23 | 383,522,279.90 | 454,337,639.88 | 570,381,728.74 | 660,214,815. |
| **LOW OPTION** | | | | | | | | |
| (1) Psychiatric | 515,091.40 | 634,425.00 | 575,435.59 | 596,699.73 | 898,759.43 | 1,208,543.77 | 1,439,782.12 | 1,844,337. |
| (2) All Other | 13,869,045.49 | 16,246,555.42 | 15,234,110.72 | 16,725,380.33 | 20,611,095.13 | 25,384,021.84 | 30,100,792.69 | 36,797,610. |
| (3) Total | 14,384,136.89 | 16,880,980.42 | 15,809,546.31 | 17,322,080.06 | 21,509,854.56 | 26,592,565.61 | 31,540,574.81 | 38,616,767. |
| **BOTH OPTIONS** | | | | | | | | |
| (1) Psychiatric | 9,944,466.73 | 14,075,654.04 | 13,644,507.49 | 18,557,494.52 | 25,364,286.69 | 31,045,833.51 | 41,801,830.09 | 49,796,557. |
| (2) All Other | 214,229,632.11 | 288,096,025.50 | 263,526,765.88 | 318,205,461.77 | 379,667,847.77 | 449,884,371.98 | 560,120,473.46 | 649,045,024. |
| (3) Total | 224,174,098.84 | 302,171,680.34 | 277,171,273.37 | 336,762,956.29 | 405,032,134.46 | 480,930,205.49 | 601,922,303.55 | 698,851,583. |

[illegible] by Type of Service, [illegible]

| | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 |
|---|---|---|---|---|---|---|---|---|
| **HIGH OPTION** | | | | | | | | |
| (1) Psychiatric | $ 52,571,567.06 | $ 59,153,224.92 | $ 66,956,069 | $ 87,066,012 | $ 103,657,494 | $ 111,110,077 | $ 117,287,845 | $ 129,796,422 |
| (2) All Other | 665,690,280.10 | 739,658,147.78 | 854,693,384 | 1,051,082,188 | 1,221,503,432 | 1,300,665,651 | 1,441,419,876 | 1,531,605,305 |
| (3) Total | 718,261,847.16 | 798,811,372.70 | 921,649,453 | 1,138,148,200 | 1,325,160,926 | 1,411,776,728 | 1,558,707,711 | 1,661,401,727 |
| **LOW OPTION** | | | | | | | | |
| (1) Psychiatric | 1,942,638.99 | 2,550,707.81 | 3,173,021 | 3,710,655 | 4,782,262 | 5,337,564 | 6,264,331 | 6,950,995 |
| (2) All Other | 40,167,846.26 | 46,850,414.84 | 54,309,584 | 64,598,349 | 76,755,334 | 88,302,590 | 105,204,822 | 122,390,931 |
| (3) Total | 42,110,485.25 | 49,401,122.65 | 57,482,605 | 68,309,004 | 81,537,596 | 93,640,154 | 111,469,153 | 129,341,926 |
| **BOTH OPTIONS** | | | | | | | | |
| (1) Psychiatric | 54,514,206.05 | 61,703,932.73 | 70,129,090 | 90,776,667 | 108,439,756 | 116,447,641 | 123,552,176 | 136,747,417 |
| (2) All Other | 705,858,126.36 | 786,508,562.62 | 909,002,968 | 1,115,680,537 | 1,298,258,765 | 1,388,968,441 | 1,546,624,698 | 1,653,991,738 |
| (3) Total | 760,372,332.41 | 848,212,495.38 | 979,132,058 | 1,206,457,204 | 1,406,698,521 | 1,505,416,882 | 1,670,176,924 | 1,790,735,055 |

## EXHIBIT 3

## PSYCHIATRIC ADMISSIONS

## INCURRED 1977 - PAID THROUGH 9/30/79

| | Member Hospitals | HHC | Non-Public Psychiatric | N. Y. State Hospitals | County & Federal | All Hospitals Combined |
|---|---|---|---|---|---|---|
| Number of Claims | 136 | 2 | 177 | 39 | 15 | 369 |
| Days | 2,642 | 6 | 16,842 | 1,390 | 121 | 21,001 |
| Average L. O. S. | 19.43 | 1 | 95.15 | 35.64 | 8.06 | 56.91 |
| Per Diem Incl. Supp | $150.17 | $198.32 | $182.16 | $68.87 | $243.34 | $171.16 |
| $R_t$* | | | | | | |
| t 21 | .7100 | Insufficient | .1957 | .3986 | Insufficient | .2784 |
| 30 | .8461 | Data | .2637 | .5137 | Data | .3571 |
| 45 | .9412 | To Be | .3595 | .6590 | To Be | .4565 |
| 60 | .9765 | Meaningful | .4378 | .7741 | Meaningful | .5313 |
| 90 | 1.0000 | | .5609 | .9266 | | .6430 |
| 120 | 1.0000 | | .6606 | .9633 | | .7254 |
| 150 | 1.0000 | | .7406 | .9849 | | .7910 |
| 180 | 1.0000 | | .8057 | 1.0000 | | .8442 |
| 201 | 1.0000 | | .8438 | 1.0000 | | .8747 |
| 250 | 1.0000 | | .9146 | 1.0000 | | .9315 |
| 300 | 1.0000 | | .9647 | 1.0000 | | .9717 |
| 365 | 1.0000 | | 1.0000 | 1.0000 | | 1.0000 |

---

$R_t$ is as per definition in Gingery paper on hospital continuation tables, i.e., the % of total days within the first "t" days.

## SOCIAL WORKER COVERAGE
## AS OF DECEMBER 31, 1979

| | Premium Earned | Claims Incurred | Participants | % of All Groups |
|---|---|---|---|---|
| Buffalo BS | $110 | N/A | 249 | .06% |
| New York BC/BS | 15 | -0- | 17 (approx.) | .002 |

---

NOTES: (1) Both Buffalo and New York Riders were sold to one group each.

(2) Rochester Blue Cross/Blue Shield sold rider in 1980 to one group with 261 subscribers.

## COMMERCIAL INSURANCE COMPANIES

**Results of Survey Requesting Policyholder Data and Premium and Claims Experience for Contracts and Riders Written Pursuant to Chapters 893 and 894 of the Laws of 1977.**

STATE OF NEW YORK — INSURANCE DEPARTMENT
INTER-OFFICE CORRESPONDENCE

RECEIVED
AUG 26 1980
ALBANY, NEW YORK

*To* Deputy Superintendent Clyne — DATE August 25, 1980
*From* Robert C. Nuding
*Subject* Chapters 893 and 894 of the Laws of 1977

Our letter of January 22, 1980 (copy attached) concerning Chapter 894 and Chapter 893 of the Laws of 1977, requested certain experience data from insurers issuing health insurance policies in this State.

The difficulties and complexities of such a request were perhaps not fully appreciated at the time, thus, it has taken a longer time than anticipated to complete the report. The following paragraphs taken from the replies of several insurers active in New York, illustrate quite well the nature of the problems.

Equitable Life Assurance Society

"Claim payments under a group policy are not recorded on a benefit basis, but rather are recorded and totalled in broader categories. The benefits paid for the coverages included in Chapter 893 and 894 are not totalled separately. Therefore, experience on items 1 and 2 is not available."

Health Service Incorporated

"Premium rates are too small to be significant; benefits reported are included in major medical coverage. On major medical reporting, no differentiation between providers is recorded."

Mutual of New York

"Premium and claims experience for statutory benefits - as coverage for the diagnosis and treatment for mental, nervous and emotional disorders has been routinely included in our major medical premium, no separate premium and claims experience figures have been maintained for statutory (or better than statutory), benefits."

Connecticut General

"Our standard offerings under our group medical expense products already provide the greater part of the benefits described in Chapter 894, and in some respects exceed them. For example, the maximum amount payable for out-patient treatment of mental, nervous and emotional conditions under our policies is $1,000 in a calendar year rather than $700. These benefits are payable under Major Medical and Comprehensive Medical plans. We have had no requests from our policyholders to provide the exact benefits which we were required to make available under Chapter 894."

Form 349. 10-21-69-50M (881-314)

SIGNED______________________________

"With respect to services performed by a certified and registered social worker, which we were required to make available under Chapter 893 of the laws of 1977, we provide this coverage administratively under all our New York group medical plans, without any change in rates. Claims are paid for charges made by a social worker for diagnosis and treatment of mental, nervous or emotional disorders to the same extent as for charges made by a physician or a psychologist. These benefits are payable under Major Medical and Comprehensive Medical Plans."

"We have not differentiated between the types of provider as to relative frequencies of treatment and average total covered expenses, and therefore we are unable to provide any information as to whether such coverage has had an impact on the costs of insurance coverage for mental and nervous conditions."

Based on replies to our letter of January 22, 1980 the attached table of coverage of mental and nervous services for commercial carriers was prepared. We may conclude, from these results, that coverage for mental and nervous conditions is in effect for a great many residents of New York State, especially on an in-patient basis. Coverage on an out-patient basis, while extensive, has not been as widespread, due to the continuing difficulty of maintaining cost-effectiveness in an area which has always been subject to the problems of overutilization and high costs. Similarly, any potential for savings and other benefits from extension of insurance coverage to include services of social workers has not as yet been recognized and therefore fewer groups have selected this optional coverage.

Attached is a copy of the original letter and an exhibit which lists and summarizes the replies received.

Robert C. Nuding
Chief, A & H Rating Section

RCN/blc

STATE OF NEW YORK
INSURANCE DEPARTMENT
AGENCY BUILDING ONE
EMPIRE STATE PLAZA
ALBANY, NEW YORK 12257

ALBERT B. LEWIS
Superintendent of Insurance

Re: Chapter 894 and Chapter 893 of the Laws of 1977 — Experience Data

Dear

Chapter 894 of the Laws of 1977, enacted to take effect on January 1, 1978, required every insurer issuing group policies for delivery in this State which provide coverage for in-patient hospital care, and every Article IX-C Corporation which provides in-patient hospital care and/or physician services, to make available, coverage for the diagnosis and treatment for mental, nervous and emotional disorders. The Department, by Circular Letter No. 18 (1977), dated December 19, 1977, set forth guidelines for the approval of policy forms and premium rates to implement Chapter 894.

Your attention is directed to Section I, Paragraph (I), which states in part "Each insurer and Article IX-C Corporation shall maintain separate experience data for this coverage." More than two years have elapsed since the effective date of this Law and companies should be in a position to provide the Department with their experience data. Accordingly, you are requested to provide the undersigned, as soon as possible, but no later than 60 days from receipt of this letter, your Company's experience under this coverage. The experience should be reported in the following manner:

1. Premium and claims experience for the statutory benefits;

2. Premium and claims experience for the benefits which are equal to or greater than the statutory benefits;

3. The number of policyholders selecting the statutory coverage, the number of covered employees, and the percentage compared to all group policyholders;

4. The number of policyholders who have benefits equal to or greater than the statutory benefits, the number of covered employees and the percentage compared to all group policyholders;

5. For each of the above items, please identify the type of health coverage to which these benefits have been made a part, i.e., "basic", "major medical", etc.

Circular Letter No. 18 also included guidelines covering Chapter 893 of the Laws of 1977, with regard to coverage for services performed by certified and registered social workers.

A number of insurers in making this coverage available have determined that an additional charge was not necessary. Other insurers have included this benefit with out-patient mental and nervous coverage.

Where no premium is being charged it will not be possible to comply with items 1. and 2, as outlined above. In addition, where premium rates are so small as to be insignificant, such as in relation to overall coverage under a Major Medical plan, reporting of experience in the above format may not be possible. However, items 3, 4, and 5, should be furnished, as should information as to relative frequencies of treatment and average total covered expenses, differentiated between the types of provider, i.e. by social workers vs. physicians, psychiatrists and psychologists. Such information should indicate whether such coverage has increased, decreased, or had no impact on the costs of insurance coverage for mental and nervous conditions.

Please acknowledge receipt of this request, indicating when such information will be submitted.

Very truly yours,

Raymond A. d'Amico

Raymond A. d'Amico, JD, CLU, CPCU
Chief, Health & Life Policy Bureau

Rd'A:sc

## COVERAGE OF MENTAL & NERVOUS SERVICES -- COMMERCIAL INSURERS

| Company | Premium & Claims Experience* | Benefits at Statutory Level: # Policyholders | Benefits at Statutory Level: # Employees | Benefits at Statutory Level: % Compared to All NY Grp. Policies | Type of Benefit (B, MH or CM) | Benefits Equal to or Better than Statutory Level: # Policyholders | Benefits Equal to or Better than Statutory Level: # Employees | Benefits Equal to or Better than Statutory Level: % Compared to All NY Grp. Policies |
|---|---|---|---|---|---|---|---|---|
| Allstate | | 0 (0) | 0 (0) | 0 (0) | MH | 1 (0) | 1,364 (0) | 100 (0) |
| American General | | | | NOT AVAILABLE | | | | |
| Bankers Life & Casualty | | | | NOT AVAILABLE | | | | |
| Bankers Mult. Line | | | | NO BUSINESS INFORCE | | | | |
| Bankers Security | | 1 (1) | 355 (355) | 100 (100) | MH | 143 (143) | 2,466 (2,466) | 100 (100) |
| | | | | | | | | |
| Beneficial National | | | | NO BUSINESS INFORCE | | | | |
| Colonial Life | | 0 (0) | 0 (0) | 0 (0) | MH | 1,988 (6) | 41,878 (311) | 100 (-) |
| Colonial Penn Franklin | | | | NO BUSINESS INFORCE | | | | |
| Columbian Mutual | | 17 (199) | 60 (702) | 9 (100) | MH | 0 (0) | 0 (0) | 0 (0) |
| Companion | | | | NOT AVAILABLE | | | | |
| | | | | | | | | |
| Connecticut General | | | | NOT AVAILABLE | | | | |
| Continental Casualty | | | | NOT AVAILABLE | | | | |
| Cuna Mutual | | 0 (0) | 0 (0) | 0 (0) | MH | 66 (0) | 172 (0) | 100 (0) |
| Equitable | | 0 (0) | 0 (0) | 0 (0) | CM, MH | 35 (0) | 28,711 (28,963) | 13 (7) |
| Fiduciary | | | | NOT AVAILABLE | | | | |
| | | | | | | | | |
| Fireman's Fund | | 7 (0) | 2,172 (0) | 77 (0) | B, MH | 0 (0) | 0 (0) | 0 (0) |
| Government Employees | | 0 (0) | 0 (0) | 0 (0) | B, MH | 2 (2) | 434 (434) | 100 (100) |
| Guardian | | 0 (0) | 0 (0) | 0 (0) | MH | 3,347 (3,347) | 103,115(103,115) | 28 (28) |
| Hartford Life | | 0 (0) | 0 (0) | 0 (0) | B, CM, MH | 275 (275) | 25,882 (25,882) | 100 (100) |
| Health Service, Inc. | | 0 (0) | 0 (0) | 0 (0) | MH | 1,353 (0) | 800,506 (0) | 50 (0) |
| | | | | | | | | |
| Home Life | | | | NOT AVAILABLE | | | | |
| INA Life | | 0 (0) | 0 (0) | 0 (0) | -- | 0 (0) | 0 (0) | 0 (0) |
| John Alden | | | | NO BUSINESS INFORCE | | | | |
| John Hancock | | | | NOT AVAILABLE | | | | |
| Kemper | | | | NOT AVAILABLE | | | | |
| | | | | | | | | |
| Liberty Mutual | | 13 (0) | 5,220 (0) | 9 (0) | MH | 127 (140) | 52,780 (58,000) | 91 (100) |
| Massachusetts Mut. | | 18 (18) | 774 (774) | 2 (2) | MH | 778 (778) | 60,488 (60,488) | 98 (98) |
| Metropolitan | | | | NOT AVAILABLE | | | | |
| Monarch | | | | NOT AVAILABLE | | | | |
| Mutual Benefit | | | | NOT AVAILABLE | | | | |

| | | Benefits at Statutory Level | | | | Benefits Equal to or Better than Statutory Level | | |
|---|---|---|---|---|---|---|---|---|
| Company | Premium & Claims Experience* | # Policyholders | # Employees | % Compared to All NY Grp. Policies | Type of Benefit (B, MM or CM) | # Policyholders | # Employees | % Compared to All NY Grp. Policies |
| Mutual of New York | | 24 (5) | 3,761 (135) | 21 (5) | MM | 88 (0) | 2,969 (0) | 79 (0) |
| Mutual of Omaha | | | | NOT AVAILABLE | | | | |
| Nationwide Life, Mut. | | 66 (0) | 7,960 (0) | 87 (0) | B, MM | 5 (76) | 1,000 (9,615) | 7 (100) |
| New England Life | | | | NOT AVAILABLE | | | | |
| New York Life | | 0 (0) | 0 (0) | 0 (0) | MM | 2,242 (2,242) | 134,582 (134,582) | 100 (100) |
| Penn Mutual Life | | 0 (0) | 0 (0) | 0 (0) | B, MM | 18 (18) | 2,460 (2,460) | 100 (100) |
| Phoenix Mutual | | | | NOT AVAILABLE | | | | |
| Provident Life & Cas. | | 0 (0) | 0 (0) | 0 (0) | MM | 53 (53) | 16,548 (16,548) | 79 (79) |
| Provident Mutual | | 0 (1) | 0 (14) | 0 NA | MM | 0 (0) | 0 (0) | 0 (0) |
| Prudential | | 0 (0) | 0 (0) | 0 (0) | B, MM | 6,898 (6,781) | 475,531 (29,951) | 100 (98) |
| Security Mutual | | 0 (0) | 0 (0) | 0 (0) | MM | 16 (0) | 5,760 (0) | 50 (0) |
| Sentry Life | | 42 (42) | 400 (400) | 100 (100) | MM | 0 (0) | 0 (0) | 0 (0) |
| State Farm | | | | NO BUSINESS INFORCE | | | | |
| State Mutual | | 0 (0) | 0 (0) | 0 (0) | CM, MM | 85 (1) | 6,496 (1,400) | 100 (-) |
| TIAA CREF | | 22 (22) | 2,287 (2,287) | 13 (13) | CM, MM | 204 (204) | 36,344 (36,344) | 55 (55) |
| Trans World | | | | NO BUSINESS INFORCE | | | | |
| Travelers | | 10 (1) | 150 (34) | 1 (2) | MM | 1,330 (34) | 19,800 (1,826) | 75 (7) |
| Union Labor Life | | 0 (0) | 0 (0) | 0 (0) | MM | 115 (41) | 100,460 (36,272) | 100 (35) |
| Union Mutual Life | | 452 (452) | 23,977 (23,977) | 100 (100) | MM | 0 (0) | 0 (0) | 0 (0) |
| Unionmutual Stock Life | | 491 (491) | 16,721 (16,721) | 100 (100) | MM | 0 (0) | 0 (0) | 0 (0) |
| United States Life | | 0 (2) | 0 (25) | 0 (1) | MM | 8,000 (8,000) | 55,000 (55,000) | 100 (100) |
| Unity Life | | | | NO BUSINESS INFORCE | | | | |
| Zurich | | 0 (0) | 0 (0) | 0 (0) | MM | 2 (2) | 1,100 (1,100) | 100 (100) |

**TOTALS**

| | STATUTORY | | | | EQUAL OR BETTER THAN STATUTORY | | | |
|---|---|---|---|---|---|---|---|---|
| | # Policyholders | | # Employees | | # Policyholders | | # Employees | |
| | MN | SW | MN | SW | MN | SW | MN | SW |
| Totals | 1,141 | 1,234 | 43,817 | 45,446 | 27,371 | 22,351 | 1,975,846 | 891,239 |

*No company able to supply premiums and claims experience
Numbers in parenthesis indicate Social Worker coverage
B - Base Benefits
MM - Major Medical
CM - Comprehensive Medical
MN - Mental and Nervous Coverage of Psychiatrists' & Psycholigists' Services
SW - Social Workers Covered for Mental and Nervous Services

7

BLUE SHIELD
of California

720 California Street • San Francisco • Califor
Mail Addr... P. O. Box [illegible], San Francisco, CA 9[illegible]

June 3, 1980

[illegible]
Psychiatrist
Psychotherapy, [illegible]
THE EUGENE HO
1162 WILLA
EUGENE

Mr. John B. Milnes, M.S.W.
1495 Kathy Street South
Salem, Oregon 97302

Dear Mr. Milnes:

Your letter to Dr. Schaffarzick regarding payments for services rendered by social workers has been referred to this department for reply.

Effective January 1, 1977 health plans in California which allow for professional psychiatric coverage are to provide payments for services performed by Clinical Social Workers licensed by the Board of Behavioral Science Examiners and performed within the scope of their license. Of course, all terms, conditions, limitations and exclusions of contract provisions for the psychiatric benefit would apply.

We have made no studies which would definitively answer your two question (1) Will insurance rates go up excessively by including Clinical Social Workers as providers? and (2) Will the quality of psychotherapeutic treatment be maintained? Although about two-thirds of Blue Shield of Californi subscribers have some professional psychiatric coverage, usually it is limited by copayments and maximums. Typical benefits would cover 50% of the first $20 (option: $40) of charges per visit with a maximum of 50 vis (option: 100 visits) per calendar year. Because the coverage of psychotherapeutic services is a small part of the total health package, the expansion of allowable providers for such benefits would have little impac on the total rates for health coverage.

We regret that this is one of the areas where statistics are not readily available.

Sincerely,

Walter Chan,
Senior Actuarial Analyst
Actuarial Department

/kgm
xc: Dr. Schaffarzick

55

GROUP
INSURANCE
DEPARTMENT **bulletin**

May 15, 1979

S-79-29

DIVISION AND GENERAL MANAGERS

Attention: Group Sales Department

CLINICAL PSYCHIATRIC SOCIAL WORKERS

We have liberalized our claim practices to administratively include expenses charged by any licensed Clinical Psychiatric Social Worker.

The requirements are that the attending physician (psychiatrist) must specifically refer the patient to the Clinical Psychiatric Social Worker associated with the physician's office and the charges payable cannot exceed those payable for out-patient psychiatric treatment.

This change is effective immediately and no charge will be made.

Group Sales Department

Printed in U.S.A.

THE HARTFORD

# Psychotherapy Finances

1980
SURVEY
REPORT

PRACTICE SUPPLEMENT

Volume 7, No. 7 (Section 2) OCTOBER 1980

## FULL-TIME PRACTICE: Results for those committed to private practice

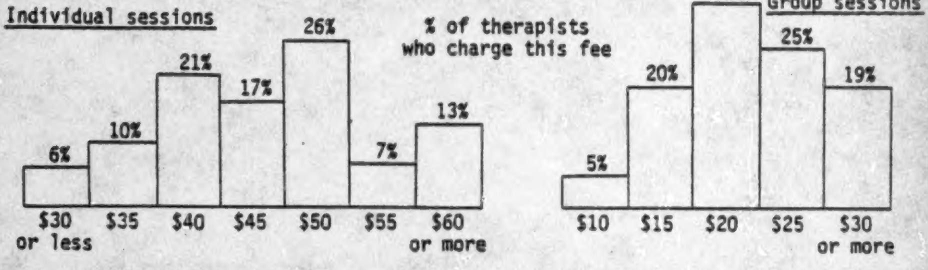
For the first time, our survey computer program allowed us to break out the figures for therapists who characterize themselves as full-time practitioners--about 800 therapists or two-thirds of those covered in the total survey results. The full-time subgroup turns out to have a higher number of Ph.D.s--68% to 59%--a higher proportion of males; and a greater number of years in private practice. There are also relatively fewer full-timers in the East compared to other regions.

Median hours seeing patients is 26 per week for full-timers--compared to 10 hours per week for part-timers. However, over one-fifth of full-timers see patients in offices for 35 or more hours each week. Full-timers are also more likely to have group sessions (50%) than part-timers (30%), although almost 90% schedule four hours or less for groups weekly. They also have shorter sessions.

The median fee for full-time private practitioners is $45--$5 more than the median for part-timers--but the differences are even greater in the higher fees. 30% more charge $50; $75% more charge $55; and 300% more charge $60 or above. In addition, full-timers were slightly more likely to have increased their fees during the past year and are planning more fee increases than part-timers now.

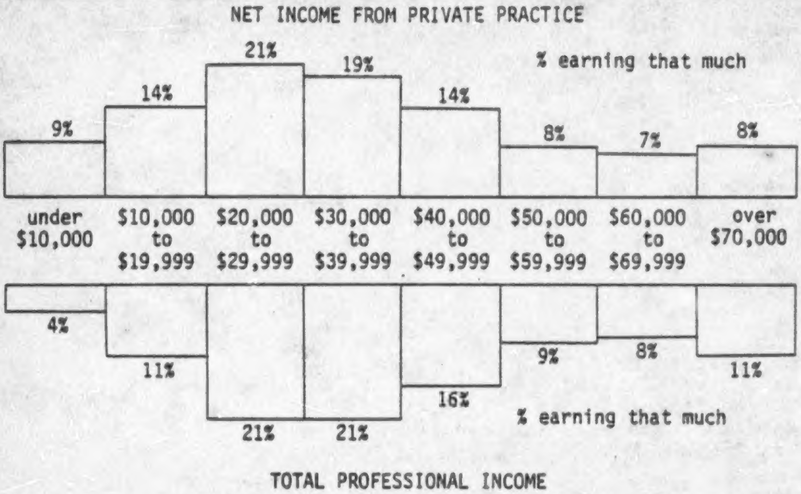
Insurance reimbursements are much more likely to be an important part of the incomes of those in full-time private practice than of the incomes of part-timers. Only 6% report that none of their patients have insurance coverage of some kind--and over one-fifth say that 80% to 100% of their patients have some insurance. How much actual income comes from third parties? 29% get 60% or more of their incomes via reimbursements; 37% get from 20% to 60%--the rest get less than 20%. Yet with all these claims for reimbursement, only half report some difficulties.

FEES IN FULL TIME PRACTICE



Note: Charts and ~~tables may not equal~~ 100% because of rounding.

**********OVER**************



Group practice is about as likely among full-timers as among part-timers, a little under one-third of each type of practice is set up that way--including those sharing expenses but not otherwise professionally connected to each other. But three times as many of the full-time private practitioners are likely to be incorporated (23%) since they have higher incomes and can take advantage of tax benefits of incorporation--mainly the chance to deduct higher pension payments.

Keogh or IRA Plan

| Pension plan contribution | Deducting that amount |
|---|---|
| None | 18% |
| $ 1-499 | 3 |
| 500-1,499 | 9 |
| 1,500-2,999 | 27 |
| 3,000-4,499 | 15 |
| 4,500-5,999 | 9 |
| 6,000-7,499 | 7 |
| 7,500 + | 12 |

Corporate plan

| Pension plan contribution | Deducting that amount |
|---|---|
| None | 28% |
| $ 1-4,999 | 15 |
| 5,000-9,999 | 20 |
| 10,000-14,999 | 17 |
| 15,000-19,999 | 8 |
| 20,000-24,999 | 8 |
| 25,000 + | 4 |

Median net income from private practice is $33,157 for full-time private practitioners--more than half of those in part-time practices net under $10,000. Total professional income, moreover, has a median of $37,800--more than $10,000 above the total professional income of part-time private practice therapists. Altogether, about one-quarter of the full-timers have a salaried position of some kind--although more than half work under 10 hours at the salaried job each week.

Practice expenses of full-timers are much higher than those of part-timers, as you'd expect--the median is just about $10,000. In contrast, about one-third of the part-timers report that their practice expenses are under $2,500 annually, and another 25% spend between $2,500 and $5,000. In contrast, 20% of those in full-time private practice have expenses of $15,000 to $25,000 and about 10% spend between $25,000 and $35,000. A future report will give expense ratios.

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THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES
1285 Avenue of the Americas, New York, N.Y. 10019

554-1234 MISS URBAN.

PETER A. LIPUMA
Vice President
BENEFIT PLANS DEPARTMENT

January 27, 1981

Mr. Patrick H. De Leon
Executive Assistant
United States Senate
Room 105, Russell Senate Building
Washington, D.C. 20510

Dear Mr. De Leon:

Effective January 1, 1981 Equitable increased the benefits for outpatient psychiatric care. The change effected the calendar year limit as well as increasing the amount reimbursed for each visit. The change was made to recognize the rising cost of health care and to be more realistic by recognizing the current fees charged by psychiatrists

The change in our plan now permits reimbursement for psychiatric social workers. This change recognizes that adequate psychiatric counseling can be provided by qualified people other than psychiatrists and generally at a lower cost. These provisions in our plans are relatively new and we do not have any statistical information at this time that suggests that increasing mental health coverage would be cost-effective.

We plan to do some serious research work in 1981 and I would suggest that you contact me again early in 1982.

Sincerely,

Peter LiPuma

PENDING

## LOUISIANA FACT SHEET ABOUT

## LEGISLATION DESIGNATING BOARD CERTIFIED SOCIAL WORKERS FOR REIMBURSEMENT FOR TREATMENT OF NERVOUS AND MENTAL DISORDERS

Q. How much will this legislation cost the State of Louisiana?
A. Actually, this legislation will save the state money. State facilities and not-for-profit agencies would be reimbursed for the services of their clinical social workers, saving scarce tax dollars and voluntary donations. Tax and voluntary dollars would be used to subsidize consumers who who do not have mental health coverage in their group health insurance or do not have any group health insurance at all (usually the poor).

Q. Who will qualify for reimbursement?
A. Only social workers properly licensed in Louisiana could be reimbursed. The Louisiana licensing Law for Social Workers (Louisiana Revised Statutes 37:2701 et seq.) requires a Master of Social Work degree plus two years of supervised practice, plus an examination. In addition to be reimbursed a social worker must be a member of a recognized clinical registry.

Q. Why is this legislation needed in Louisiana?
A. In many parts of the State of Louisiana, Social Work Services are the only mental health services available. In forty-six parishes there are no psychiatrists, in the seven parishes there are one, in three parishes there are two to four, in two parishes there are seven to eight, in one parish there are eleven, in one parish there are thirteen, in two parishes there are seventeen, in one parish there are twenty, and there are one hundred twenty-two in Orleans Parish.

Q. What is the role of Social Workers in treating mental and nervous disorders?
A. In 1980, in State Mental health centers and substance abuse clinics 64% of the treatment personnel are social workers. (See office of Mental Health and Substance Abuse - Summary of 1979-80 Budgeted positions). The role of the psychiatrist in State Mental Health centers is diagnosis, medication, and an overview of treatment. Direct treatment is rendered by social workers. Social Workers who perform this kind of treatment are called clinical social workers, psychiatric social workers, or mental health social workers. They work in agencies supported by voluntary donations such as United Way as well as in tax-supported facilities. Some are in private practice.

Q. Does Social Work treatment for such disorders cost less than psychiatric treatment?
A. In 1980, psychiatrists in Louisiana were charging $50-$90 an hour, social workers $30-$50.

Q. Will this legislation raise insurance premiums?
A. There is no reason to believe that insurance premiums will rise. Bankers Life of Des Moines, Iowa and Union Labor Life Insurance Co. of New York City, two of the largest underwriters of health insurance, both include Social Workers in their Standard Major Medical package as independent vendors. Neither company requires a premium increase for inclusion of Social Workers. Blue Cross/Blue Shield of New York City, Blue Shield of California, Blue Shield of Maryland, and Blue Shield of Washington, D.C. and Blue Cross/Blue Shield of Utah are a few of the Blue Cross/Blue Shield organizations that currently issue policies which include social workers under mental health coverage.

Q. Does private enterprise use Social Worker services?
A. Standard Oil of California recently revised its mental health coverage for employees to emphasize utilization of social workers rather than psychiatrists and psychologists because its Special Health Services Unit believes that the services obtained from Licensed Social Workers are more effective, and less expensive. A study of the Kaiser-Permanente's 16 year experience with mental health benefits showed that patients who underwent only brief psychotherapy showed a 75% reduction in medical utilization over a five-year period.

Prepared by: Louisiana State Chapter, National Association of Social Workers
Ed Reed, Legislative Consultant

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UNITED NATIONS

SECRETARIAT

ST/IC/78/21
5 April 1978

## INFORMATION CIRCULAR

To: Members of the staff

From: The Assistant Secretary-General (Controller)
Office of Financial Services

Subject: AETNA/BLUE CROSS/MAJOR MEDICAL INSURANCE PLAN - 1978

1. The purpose of this circular is to inform the staff of improvements made in the coverage under the Aetna Base and Major Medical components of the Aetna/Blue Cross/Major Medical insurance scheme and in the Major Medical component of the HIP/Blue Cross/Major Medical scheme.

2. Effective 1 January 1978, the out-of-pocket amount payable by subscribers before the reimbursements of covered expenses under Major Medical are effected at 100 per cent instead of at 80 per cent, was reduced from $1,000 per person per calendar year to $500.

3. Effective 1 April 1978, maternity coverage was placed on the same basis as that existing for the treatment of other medical conditions under the provisions of the plan. Consequently, the flat amount limitations under the maternity coverage announced and described in information circular ST/ADM/SER.A/1867 of 29 May 1975 will no longer apply. Instead, the amounts of reimbursement for services by a physician in connexion with maternity care will be subject to the same reasonable and customary cost criteria applied in respect of other medical services.

4. Coverage of the charges for the services of a duly licensed social worker will be provided, effective 1 April 1978, if those charges would have been covered under the policy for similar services rendered by a physician, psychiatrist or psychologist. The services also must be within the lawful scope of practice of the social worker. In addition to the educational certification requirements, the social worker must have either: (a) three years' post-degree experience in psychotherapy under supervision, satisfactory to the State Board of Social Work, in a facility providing services for diagnosis and treatment of mental, nervous or emotional disorders or ailments; or (b) three years' post-degree experience in psychotherapy under the supervision, satisfactory to the State Board of Social Work, of a psychiatrist, a certified registered psychologist, or a social worker qualified for reimbursement. It is not required that the patient be referred to the social worker by a physician.

5. Despite the fact that the cost of health care has risen sharply during the previous year and is expected to continue to rise in 1978, it has been possible to introduce the improvements described above without an increase in the contributions for 1978. Since the Aetna/Blue Cross/Major Medical plan is experience rated, changes in the premium costs are determined in the main by the amounts reimbursed during the previous year to subscribers in respect of medical claims submitted. The favourable reimbursement experience under the plan in 1977 has made it possible to effect coverage improvements without increased costs.

6. The premium and contribution rates for the group insurance schemes shown in the annex to information circular ST/IC/77/15 of 11 February 1977 remain unchanged at this time.

[Subsequent to the hearing, Mr. Gradison submitted the following questions:]

1. Researchers are finding that a substantial portion of conditions that have been traditionally thought to be psychological in nature are in fact organic diseases treatable by drugs. In addition the most common cause of dementia-like symptoms in older people is adverse drug reaction. Are non-physician mental health practitioners qualified to sort out psychological from physiological conditions?

2. I noticed from the data that you have provided from the CHAMPUS program that in some states there is very little difference between what a clinical social worker and a psychiatrist charge for psychotherapy services. For example, I call your attention to southern Calilfornia where a psychiatrist's fee is $85 and a clinical social worker's fee is $75 per 45-50 minute session. In D.C. and Alaska there is only a $5 differential in fees. In South Carolina and Wyoming the fees are identical. Doesn't this fly in the face of the argument being made by non-physician practitioners that direct payment for their services will be less costly?

3. If Medicare pays non-physician practitioners on the same basis as physicians won't there be a tendency over time for everyone to bill about the same amount is any given area of the country?

NAS W

**NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.**
7981 Eastern Avenue, Silver Spring, Maryland 20910 (301) 565-0333

January 20, 1983

John J. Salmon
Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Salmon:

Thank you for the opportunity to respond to your questions regarding the materials submitted as part of my testimony before the Subcommittee on Health on December 14, 1982.

1. It has been our experience that clinical social workers, psychologists and other mental health practitioners are trained to be sensitive to behavior that may be influenced by physiological factors. A competent therapist regardless of discipline will seek consultation from specialists in order to confirm or seek out the existence of physiological conditions that could be influencing the patients behavior. It is often a non-physician who provides the diagnostic clues and supporting evidence of a physiological condition through observation, history taking and/or testing.

2. The CHAMPUS date indicates that some social workers' fees are close to that of some physicians. If one further examines the data it becomes quite clear that Southern California, Wyoming and South Carolina are exceptions. The study does support our contention that:

A. clinical social workers charge less than physicians,
B. recognizing clinical social workers will be cost effective. In this period of inflated costs an eight to twelve percent reduction in cost will not be an insignificant sum. There are many factors that influence the fees charged by practitioners. Competencey and quality are important considerations. A high fee by an experienced clinical social worker may, in the long run, be less expensive than care provided by a relatively inexperienced physician, psychologist, or clinical social work who charges a lesser fee. Unfortunately the study does not provide comparisons for length of treatment, treatment outcomes and total treatment costs. Nor does it provide any information on the experience of the provider.

3. A 1982 survey conducted by our California Chapter showed that of 93 clinical social workers who had seen CHAMPUS patients during the preceding year charged a standard fee which ranged from $20 to $75 per 45-50 minute hour. The fee range was similar for a total of 337 respondents to the survey.

John J. Salmon
Page 2

Obviously there are many factors which enter into a therapist's decision on his/her fee. Cost of living and prevailing rates in the specific geographic area, age, experience, competition, and availability of patients are a few of the factors.

I believe that our Association would support a uniform cap on fees for all providers in order to keep costs at an acceptable level. We would not support a cap that discriminated against particular provider groups. The quality of the treatment should be the primary concern. We are not aware of any studies that show that the outcome of treatment using psychotherapy as the primary method is more effective provided by therapists from any single discipline. Competition will be a major factor in controlling rapid fee escalation by clinical social workers and others.

I I can be of futher assistance to you, please let me know.

Sincerely,

Larry L. Burch, ACSW

Chairman JACOBS. Dr. Levitt.

## STATEMENT OF EUGENE E. LEVITT, PH. D., CHIEF, PSYCHOLOGY SECTION, DEPARTMENT OF PSYCHIATRY, INDIANA UNIVERSITY SCHOOL OF MEDICINE, ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION AND THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY, ACCOMPANIED BY CLARENCE J. MARTIN, EXECUTIVE DIRECTOR AND GENERAL COUNSEL, ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY

Dr. LEVITT. Mr. Chairman and members of the committee, I am Eugene E. Levitt. I am director of the section of psychology and professor of clinical psychology in the Department of Psychiatry at Indiana University School of Medicine in Indianapolis.

I cannot help but be struck by the number of witnesses from Indiana here this morning. I have no idea why that should be.

Chairman JACOBS. I cannot help but be struck by the fact that your title took up your whole 5 minutes.

Dr. LEVITT. And you knew it before I said it. I am accompanied by Clarence Martin, whom, as you said, everybody knows, and I am testifying on behalf of the 60,000 members of the American Psychological Association and for the Association for the Advancement of Psychology.

I would like to submit my written testimony for the record and summarize it to save the committee's valuable time, but I am still not going to win the prize. Sorry.

Chairman JACOBS. That is OK. Without objection. Mr. Schmidt will be glad. You could not win now, anyway.

Dr. LEVITT. We endorse the intent of H.R. 6092 and its two-point rationale which I call to the committee's attention again.

It has been specified before. One is to increase competition in the health care system and to expand the pool of qualified practitioners available to deliver mental health services under medicare and medicaid.

Two is to reduce the cost of federally underwritten health care benefits. We believe that this bill is being offered in recognition that physicians are clearly not the only competent practitioners of health care, that mental health services are not reaching the medicare population, and in response to the growing concern that physicians' control of the medicare and medicaid programs have artificially stifled competition and inflated the cost to beneficiaries and to the rest of the Nation's taxpayers.

When titles 18 and 19 were enacted almost 20 years ago, Congress sought to assure quality of care for the country's elderly, disabled, and poor by requiring that services be delivered by physicians and hospitals.

The experience of the past two decades has shown this approach to be disastrous in economic terms, and at least problematic in health care terms. A recent study shows that medicare pays 36 percent more for fee-for-service care than for the same care to patients as to the aged or disabled, through health maintenance organizations which make use of trained licensed nonphysician health care providers, such as psychologists and nurses.

The Federal Government acts to restrict reimbursement to nonphysician practitioners so that, at this time, medicare is the only nationwide health care financing program that does not yet recognize psychologists as fuly qualified practitioners.

The advantage for overall costs and patient care where nonmedical expertise is effective when used is well supported by research. The findings of a small group of researchers who have examined the effects of mental health treatment reducing the overall costs of medical care, submit this statement and I quote:

> An enormous body of literature suggests emotional factors may play a role in the disease process and treatment of disease may be caused by or aggravated by emotional distress, all with consequences for the course of disease recovery, maintenance of health and use of medical services.

Still another factor in support of this legislation is the commitment of Congress that no American should have to suffer in a second class system because he or she has health care financed through medicare or medicaid rather than through a private health insurance company. Congress should act to assure these citizens are allowed the same choice of practitioners as is allowed almost 90 percent of the American population who live in the 37 States where State legislatures have enacted so-called freedom of choice laws.

These laws require that health insurance plans that include benefits for services that psychologists by State law may provide must allow patients to have freedom of choice of practitioners. These statutes representing more than 88 percent of the U.S. population, and affecting 89 percent of all licensed psychologists, have been uniformly supported by both State and Federal courts.

At the present time under the Medicare Act, psychologists can participate only under supervision of physicians. Recent decisions by the Virginia Supreme Court comments on this and I quote:

> It defies logic to assume that the average family practitioner can supervise a licensed psychologist in psychotherapy, and there is no basis in the record for such an assumption.

No; when we went for these laws in the States, the psychologists said, we are going to do the supervision; we said, what about your time? Will you leave your patients and supervise us at some rate a lot lower than you get from patients? Nobody really stood up.

Recognition of psychologists and other credentialed nonmedical health professionals would clearly benefit efforts to decrease health care costs.

I don't think there is any question about the fact that psychologists and social workers charge less per patient visit than psychiatrists.

In that study by Richard Frank, assistant professor of economics and psychiatry at the University of Pittsburgh School of Medicine, it is concluded that in States with freedom of choice laws, fees for psychiatrists are lower than in States without these laws—between 8.3 and 9.5 percent lower. If we took the lower figure of this, this would amount to a saving of about $15 million under medicare benefits.

In summary, Mr. Chairman, passage of H.R. 6092 would be an important step in improving medicare and medicaid coverage for the program beneficiaries. It would allow expansion of the kinds of treatment approaches available, it would permit greater use of psychological expertise in the health care system of this country, and it would give medicare and medicaid recipients the same freedom of choice of practitioners that almost 90 percent of the U.S. population enjoys. It would contribute to lower overall costs of the medicare and medicaid program, and it would remove the illogical counterproductive and anticompetitive restrictions on the professional practice of fully trained State licensed mental health care practitioners.

I would be glad to answer any questions, Mr. Chairman.

[The prepared statement follows:]

## STATEMENT OF EUGENE E. LEVITT, PH. D. CHIEF, PSYCHOLOGY SECTION, DEPARTMENT OF PSYCHOLOGY, SCHOOL OF MEDICINE, INDIANA UNIVERSITY, ACCOMPANIED BY CLARENCE J. MARTIN, ESQ., EXECUTIVE DIRECTOR AND GENERAL COUNSEL, ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY, ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION AND THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY

Mr. Chairman and members of the Committee, my name is Eugene E. Levitt. I am Chief of the Psychology Section and professor of clinical psychology in the Department of Psychiatry at Indiana University School of Medicine in Indianapolis. I am accompanied here today by Clarence J. Martin, Executive Director and General Counsel of the Association for the Advancement of Psychology. I am testifying today on behalf of the 60,000 members of the American Psyhological Association and the Association for the Advancement of Psychology.

We fully endorse the intent of H.R. 6092 -- to increase competition in the health care system, and to expand the pool of qualified practitioners available to deliver mental health services under Medicare and Medicaid. Psychologists believe that this bill is being offered in recognition that physicians are clearly not the only competent practitioners of health care, that mental health services are not reaching the Medicare population, and in response of the growing concern that physician control of the Medicare and Medicaid programs has artificially stifled competition and inflated the cost to beneficiaries and to the rest of this nation's taxpayers.

The psychologists who would be affected by the provisions of this bill are fully-trained professionals. They are prepared through education and specialized training to provide assessment, diagnosis and treatment of mental and emotional disorders. Psychologists are licensed in all 50 states and the District of Columbia. They represent more than half of all the doctoral-level practitioners of mental health care in the United States. We estimate that among the nation's 25,000 licensed health-service-provider psychologists, there is a full-time-equivalent of 9,000 psychologists available to serve the Medicare/Medicaid populations. This is an important resource for the health care needs of the country.

When Titles 18 and 19 were enacted almost 20 years ago, Congress sought to assure quality of care for the country's elderly, disabled and poor by requiring that services be delivered by physicians and in hospitals. The experience of the past two decades has shown, however, that this approach has been disastrous in economic terms and certainly problematic in health care terms. The demand for physician and hospital inpatient services stimulated by Medicare has contributed significantly to their skyrocketing costs. At the same time, restraints on access to much ambulatory care and nonphysician providers have prevented Medicare and Medicaid beneficiaries from taking advantage of innovative and cost-efficient advances in health care.

The federal government has acted to eliminate restraints on access to nonphysician practioners such that Medicare is the only nationwide health care financing program that does not yet recognize psychologists as fully qualified practitioners. Just this year, psychologists have had their role expanded for coverage of Comprehensive Outpatient Rehabilitation Facilities, and for CHAMPUS coverage of Residential Treatment Centers. These new functions are in addition to general recognition of the services of psychologists in CHAMPUS, IN THE Veterans Administration health care system, in the Federal Employees Health Benefits Plan, in health maintenance organizations and community mental health centers, and in the Medicaid plans of 25 states.

After the introduction of Medicare, hospitalization rates among the elderly rose by 25 percent; average length of stay rose by 50 percent; and the amount of surgery on persons over age 65 rose by 40 percent. A recent study showed that Medicare pays 36 percent more for fee-for-service care than for the same care to patients matched for age, sex and location, but provided from health maintenance organizations. It is important to note that these HMOs make extensive use of trained, licensed, non-physician health care practitioners such as psychologists, social workers and nurses.

Essentially, Medicare reimburses whatever services are delivered or ordered by a physician. Although direct payments to physicians constitute only 20 percent of total health care costs, because physicians serve as the entry-point, evaluators, and decisionmakers for the disbursement of most Medicare funds, they are directly responsible for more than 70 percent of total health care spending. According to Robert Derzon, former Administrator of the Health Care Financing Administration:

> These structural characteristics coupled with physician's central decisionmaker role have resulted in a 214 percent increase in expenditures for physician services between 1965 and 1976 compared with a 145 percent increase in the Gross National Product. Over 65 percent of this increase was due to increases in prices for physician services, which...have been increasing faster than the consumer price index for the past three decades (Statement before House Subcommittee on Oversight and Investigation, Committee on Interstate and Foreign Commerce, April 7, 1978).

A more costly side-effect of physician domination over Medicare has been the system's unresponsiveness to consumer needs for the services which physicians cannot, are not trained, or are too busy to deliver.

Because of stigma, misunderstanding and fear of abuse, and perhaps because of fear of competition from nonphysician mental health professionals, mental health services were severely limited in Title 18. As the system has developed, the major portion of mental, emotional and behavioral problems of Medicare beneficiaries are being ignored, or inappropriately treated with physical interventions and in long-term institutions that provide little or no active treatment.

A recent GAO study, "The Elderly Remain in Need of Mental Health Services" (General Accounting Office, HRD-82-112, September 16, 1982), presents dramatic evidence of the failure of Medicare and Medicaid to address mental health needs of the elderly. The study points out that not only is coverage for mental health care severely limited, but the limitation on practitioners exacerbates the problem. In 1979, for instance, only 4.9 percent of the full-time-equivalent staff in Community Mental Health Centers were practitioners even eligible to be reimbursed under Medicare. Similar shortages of reimbursable practitioners occur in nursing homes and other settings catering to those over 65. Clearly, passage of H.R. 6092 would be a major step toward resolving the virtual inaccessibility of Medicare mental health services.

Persons over age 65 constitute 11 percent of our population. Yet they account for 20 percent of all reported suicides and occupy a staggering 30 percent of all public mental hospital beds. As high as 30 percent of the elderly experience depression and 18 percent have problems with alcohol. Of the 5 percent of the elderly who are nursing home residents, 50 to 75 percent experience some form of emotional or behavioral disorder. According to former HEW Secretary Joseph Califano:

> Medical education has not fully come to grips with the issue of emotional and mental problems. By one recent estimate, 60 to 70 percent of mental and emotional illness, including alochol-related problems, is treated in the medical system. This represents an important burden for thousands of physicians in the health care system: a burden for which too few are properly trained.

It has been discovered in recent research that between 10 and 20 percent of persons [illegible]tly institutionalized as "senile" have been falsely diagnosed by their [illegible]. The Conference on Treatable Diseases in the Elderly reported that [illegible] the largest single causes of this false diagnosis is drug poisoning fr[illegible]ation, tranquilizers especially, and Valium in particular. [illegible]r, former Director of the National Institute on Aging has stated that more than 100 reversible syndromes, including depression, may also mimic senile dementia.

These are some of the reported problems associated with limiting Medicare coverage to physicians; especially those types of coverage, such as mental health care, for which physicians are not sufficiently trained. Another factor should be considered, and that is the advantage for overall costs and patient care when non-medical expertise is effectively used.

Consider the findings of a group of four researchers who have been examining the effects of mental health treatment in reducing the overall costs of medical care. They state:

> "An enormous (body of) literature suggests that emotional factors may play a role in disease processes and in treatment. Disease may be caused by, or aggravated by, emotional distress, which can influence the body's ability to recover from illness and surgery. A patient's emotional responses to illness may influence both the doctor's decisions about medical treatment and the way the patient cares for himself, all with consequences for the course of disease, recovery, the maintenance of health, and the use of medical services. The literature also suggest that psychotherapy or psychologically-informed procedures are a valuable addition to ordinary medical or surgical treatment." (Herbert Schlesinger, Ph.D. et al.; "Effects of Outpatient Mental Health Treatment on Medical Utilization of Persons with Chronic Diseases." Final Report of NIMH Grant, 1980).

A similar point is appropriate for consideration in the Committee's deliberations: There are distinct advantages to the science and practice of health care when a broad range of responsible approaches and practitioners are used. This principle has guided our health research system, and it has also been used within the medical profession. However, limits on the use of expertise from the non-medical health care community have worked to the detriment of all concerned.

In connection with this, Dr. Thomas McGuire, an economist at Boston University, in his book Financing Psychotherapy: Costs, Effects, and Public Policy, makes a strong and well-supported case for including non-medical practitioners in any national health insurance program. Although the book was written for consideration in developing possible new health insurance programs, his comments are highly appropriate at these hearings to amend an existing national health insurance system -- Medicare.

Dr. McGuire states:

> "It is clear that a good deal would be lost by excluding or severely restricting the practice of psychologists under national health insurance. For the development of innovative forms of mental health delivery, it is essential that there be an adequate supply of qualified mental health professionals capable of taking a leadership role in a variety of organizations -- professionals without rigid preconceptions of the institutions within which mental health services are

> properly delivered. Psychiatrists alone would be too few and too inflexible. After the increase in demand under an NHI plan, any psychiatrist would be able to make a very good living based on independent private practice; there would be little pressure to innovate. To give further encouragement to forms of mental health delivery that have recently shown great promise it is necessary to include psychologists as independent providers."

Still another factor in support of this proposed legislation is based on the commitment of Congress to ensure that Medicare and Medicaid beneficiaries are receiving the same quality care that is enjoyed by the rest of the nation. No American should have to suffer in a second-class system because he or she has health care financed through Titles 18 or 19 of the Social Security Act rather than through one of the private health insurance companies. In light of this long-standing commitment, the Committee should act to assure that Medicare and Medicaid beneficiaries are allowed the same, pro-competitive, freedom of choice of practitioners as is allowed almost 90 percent of the American population.

Numerous state legislatures have passed what we call "freedom of choice" laws. These laws require that health insurance plans that include benefits for services that psychologists (by state law) may provide, must allow patients to have a freedom of choice of practitioners. These statutes, operative in 37 states, representing more than 88 percent of the U. S. population, and affecting the practice of 89 percent of all licensed psychologists, have been uniformly supportd by both state and federal courts as being pro-competitive and in the consumers' interest.

But freedom-of-choice statutes have been often opposed by and, once passed, frequently ignored by the medical establishment. For instance, in a recent case (Virginia Academy of Clinical Psychologists, et al., v. Blue Shield of Virginia, et al. (624 F 2nd 476 (4th Cir., 1980), it was found that the Blue Shield organization, representing its physician members, acted in restraint of trade by refusing to comply with Virginia's Freedom of Choice law. Blue Shield rules had required that psychologists function only as ancillaries to physicians; a requirement that is strikingly similar to current Medicare rules. To quote from the Court's opinion:

> "...it is not the function of a group of professionals to decide that competition is not beneficial in their line of work, (and) we are not inclined to condone anti-competitive conduct upon an incantation of 'good medical practice.' Moreover, we fail to see how the policy in question fulfills that goal..."

Importantly, the Court added the following sentence:

> "It defies logic to assume that the average family practitioner can supervise a licensed psychologist in psychotherapy, and there is no basis in the record for such an assumption."

Recognition of psychologists, and other credentialed non-medical health professionals, would clearly benefit efforts to decrease health care costs by increasing the pool of practitioners available for delivery of care. This is a fundamental economic principle. For instance, in a study by Richard Frank, Assistant Professor of Economics and Psychiatry at the University of Pittsburgh School of Medicine, it is concluded that in states with psychology Freedom-of-Choice laws, fees for psychiatrists are lower than in states without these laws -- between 8.3 and 9.5 percent lower.

The cost to the government for mental health care delivered by non-physician professionals should be an important consideration for this Committee in its deliberations on this bill. Various reports have shown that mental health care delivered by trained, state-licensed psychologists costs less than similar mental health care delivered by trained, state-licensed psychiatrists.

For example, a July 1982 report from the Civilian Health and Medical Program of the Uniformed Services (or CHAMPUS) shows that for every major therapeutic procedure, psychologists have a lower average charge than do psychiatrists. (The numbers and averages are drawn from a beneficiary population of 7 million). Although the differences in charges are not great, these differences could have a significant impact on overall Medicare/Medicaid charges when applied to the total beneficiary population in those programs.

Some of the differences in average charges reflected in the CHAMPUS data are:

| Description | Procedural Code | Type of Practitioner | Average Paid |
|---|---|---|---|
| Psychotherapy, verbal, 50 minutes (outpatient) | 90805 | Psychiatrist | $50.82 |
| | | Psychologist | $47.51 |
| Psychotherapy, adult or child, 45-50 minutes (outpatient) | 92803 | Psychiatrist | $57.58 |
| | | Psychologist | $55.75 |
| Psychotherapy, verbal, 25 minutes (inpatient) | 90806 | Psychiatrist | $31.77 |
| | | Psychologist | $26.09 |
| Psychotherapy, adult or child, 45-50 minutes, Hospital or other facility (inpatient) | 92804 | Psychiatrist | $62.24 |
| | | Psychologist | $56.91 |

Another set of statistics may be of interest to the Committee. Although this bill does not alter current coverage of mental health care under Medicare or Medicaid, the utilization of mental health services is still one consideration to be taken into account. As of October 4, 1982, according to the Health Care Financing Administration, mental health costs in Medicare represent only 2.1 percent of total costs. Further, by far the majority of beneficiaries who use their mental health coverage do so at the lowest cost to the government. For outpatient benefits, 63 percent of those who received mental health care did not exceed $100.00 in total costs. For inpatient benefits, 53 percent of those who received mental health care did not exceed 20 days of services. Additionally, the total number of persons receiving outpatient mental health care represented only 1.2 percent of total Medicare beneficiaries; the total number of persons receiving inpatient mental health care represented only 1 percent of total Medicare beneficiaries.

## Summary

Passage of H.R. 6092 would be an important step in improving Medicare and Medicaid coverage for program beneficiaries: it would allow expansion of the kinds of treatment approaches available; it would permit greater use of psychological expertise in the health care system of this country; it would give Medicare/Medicaid recipients the same freedom-of-choice of practitioners that 87 percent of the U. S. population enjoys; it would contribute to lower overall costs to the Medicare/Medicaid programs; and it would remove the illogical, counter-productive, and anti-competitive restrictions on the professional practice of fully-trained, state-licensed mental health care practitioners.

[Subsequent to the hearing Mr. Gradison submitted the following questions:]

*Question 1.* Some critics argue that psychotherapy is helpful in the same way that prayer or going to confession is helpful to some people and that it is the believing that brings help. Others say that help can be supplied just as well from friends as those who are professional counselors. Would you like to comment on those observations?

Dr. LEVITT. A distinction needs to be made between diagnosable significant mental and emotional disorders and the "ups and downs of everyday life." This distinction is not substantially different from the distinctions that are made between diagnosable significant medical illnesses and minor cuts, scrapes and bruises, or the common cold.

I do not believe it would be proper for me to comment on the spiritual or religious needs of individuals or the efficacy of confession within the context of consideration of Medicare/Medicaid benefits.

It is clear, however, that major mental and emotional disorders are not properly dealt with except by trained mental health care practitioners. A number of religious individuals are also trained counselors and have used their combination of skills, beliefs and faith to help their parishioners significantly. I am not certain that it would be an appropriate action of Congress tc declare that pastoral counselors should be the first choice of practitioner for the mentally disabled, but I do not object to the participation of fully and appropriately trained and licensed clerics/therapists in the Medicare system.

The assessment diagnosis and treatment of mental and emotional disability is immeasurably beyond the friend-helping-a-friend approach to which you allude. A thorough understanding of the behavioral and psychological components of human existence, memory, intelligence, personality, relationships, stress, fear, anxiety, etc., is absolutely necessary if the therapist must respond to the needs of mentally disabled individuals. Very few of us would want to entrust a deeply depressed and suicidal family member to "just a friend" for treatment. We would want the best available psychotherapeutic treatment—not merely to relieve symptoms, but to help that family member resolve the inner conflicts that have led him or her to seek self destruction. To suggest that dealing with that family member's problems is only slightly different than dealing with "feeling down" after watching your favorite team lose a ball game is not reasonable.

*Question 2.* Is there any relationship between psychotherapy and faith-healing?

Dr. LEVITT. I really don't know. I can't explain faith healing, and it has never been explained to me. I would not presume to argue either for or against the reality of miracles.

*Question 3.* You stated in your written testimony that physician control of Medicare and Medicaid has artificially stifled competition and inflated the cost to beneficiaries. Yet according to data I have from the CHAMPUS program where psychologists are paid on a fee-for-service basis like psychiatrists, the fees are greater than those of psychiatrists. Would you explain how fee-for-service payment to psychologists is creating competition and holding down costs in that program?

Dr. LEVITT. The statistical report from CHAMPUS borders on the irresponsible. As I indicated in my testimony, and as further illustrated by a re-analysis of the CHAMPUS data by the American Psychological Association, the CHAMPUS report compares apples to oranges, and concludes that apples are more red. A correct analysis of the CHAMPUS data, by identical treatment codes, reveals that psychologists charge less for identical types of treatments than do psychiatrists. This fact explains how fee-for-service payment to psychologists will help to hold down program costs.

Further, payment to psychologists, who are educated and trained in the assessment, diagnosis and treatment of mental and emotional disorders, will mean better and more appropriate treatment of mentally disabled individuals than the care currently being provided by general practice physicians, who are not educated, or trained, or experienced in the assessment, diagnosis or treatment of the mentally disabled. Providing appropriate and effective patient care, rather than inappropriate and ineffective care, will help to hold down program costs.

*Question 4.* There seems to be considerable controversy over the efficacy and appropriateness of some forms of mental health treatment. What is "jogging" therapy, "poetry" therapy, "dance" therapy, "Z" therapy, "hot tub" therapy "rage" therapy, "sex surrogate" therapy, "primal scream" therapy and to what extent are these modes of treatment utilized?

Dr. LEVITT. The "therapies" you mention are "Pop" names for "Pop" theories and approaches—that may or may not have anything to do with resolving mental and emotional problems. For instance, it is very difficult to deny that many forms of exercise have significant and positive side effects on a person's emotional state. This may have something to do with the release of endorphins into the blood system, or it may be due to other changes in body function that physical exercise elicits. However, "jogging therapy" is not something that I would promote for inclusion under Medicare or any other health care financing program—since it is not a form of psychotherapy—though I wonder how many physicians get reimbursed for telling a patient to lose weight (diet therapy?), and exercise regularly (jogging therapy?).

Other strange-sounding forms of therapy have proven to be very valid for use with the non-communicative institutionalized child, for instance, in helping to bring that child out of a shell and back into the world of reality. The combination of psychotherapy and directed outlets such as dance or art can be synergistically beneficial to a person who, because of a childhood of sexual and psychological abuse, for instance, has escaped a cruel existence by becoming encased in an emotional and communicative void.

"Pop therapies" are publicized in pulp magazines but are not, in fact, the kind of serious therapeutic interventions we suggest as being eligible for reimbursement. Such novel approaches are easily recognized by peer review committees and fiscal intermediaries as inappropriate, and are not reimbursed. There really is no financial threat to Medicare or to any other health care financing system from these fads.

*Question 5.* How many different types of therapy are there and how valid are they?

Dr. LEVITT. According to the Office of Technology Assessment report on psychotherapy, virtually every "type" of therapy can be included in one of three basic categories: psychodynamic, humanistic/phenomenological, and behavioral. I refer you to pages 10 to 13 of the report: "The Implication of Cost-Effectiveness analysis of Medical Technology—Background Paper #3: The Efficacy and Cost Effectiveness of Psychotherapy" October 1980, Office of Technology Assessment.

Some of the test in those pages is directly relevant to your question, and I would like to quote them here. On page 13, the OTA report reads: ". . . while the contents and procedures of psychotherapy may differ across theoretical orientations, all forms of psychotherapy share common 'healing' functions."

Further down on that same page, it is stated: "Although it is true that one source on confusion about psychotherapies is the divergent theoretical assumptions of therapists, it should also be recognized that the nature of the problems dealt with by specific therapies varies widely."

Psychotherapy is a valid intervention for dealing with mental and emotional problems. This fact has been investigated through clinical research over many years and in many settings and with many different populations. The OTA study about psychotherapy states, in its summary chapter: "In summary, OTA finds that psychotherapy is a complex—yet scientifically assessable—set of technologies. It also finds good evidence of psychotherapy's positive effects." (ibid, page 5)

*Question 6.* Is there quackery in psychology and if so what steps have been taken by the profession to deal with it?

Dr. LEVITT. I suppose I suppose there are some charletons in every profession. However I believe the American Psychological Association has done an excellent job of policing the profession and reducing abuses to a minimum.

Psychologists can purchase malpractice insurance for one million dollars worth of coverage per year for an annual premium of only fifty dollars! I believe that fact alone attests to the quality of psychological providers.

The American Psychological Association, and our affiliated state and local psychological associations, have adopted and do enforce a strong code of ethics. We have developed sets of standards for the profession called "Standards for Providers of Psychological Services" that have been approved as official APA policy. We have actively promoted licensure laws in each of the fifty states and the District of Columbia. The APA has been officially recognized by the U.S. Department of Education as an accrediting body for psychology doctoral-training programs and internship programs. The profession has created the "National Register of Health Service Providers in Psychology," a credential/reviewing oganization that, once a psychologist is determined to have met strict requirements, lists his or her name in a continually-revised registry—and the registry is used by individuals and insurance companies (including companies participating in the Federal Employees Health Benefits Plan) as a source of referral for trained and credentialed psychological practitioners. We have also created the American Board of Professional Psychology, to review a practitioner's skills and expertise and award Diplomate status in recognition of excellence.

In addition, we have created peer review bodies in each of the states, and a nationwide peer review mechanism formed in conjunction with CHAMPUS, that review treatment approaches and decisions at the request of insurance carriers. This system has been extremely effective in eliminating any waste, fraud or abuse of the mental health reimbursement programs. I would be very pleased to discuss the details of our peer review system and how it might be beneficial for reviewing, as necessary, the claims of psychologists under Medicare.

*Question 7.* Can you cite specific instances where the profession has publicly taken action against certain methods of treatment or unproven claims?

Dr. LEVITT. Each state association and the American Psychological Association have an ethics committee charged with the enforcement of the profession's ethical principles. Using the American Psychological Association's Committee as an example, in 1982 it investigated 99 cases, dismissing 30 as having no significant substance, expelling 11 members from the Association, administering 42 lesser sanctions and continuing to investigate 27.

*Question 8.* The administration testified that many elderly patients with psychiatric symptoms have problems directly related to or actually caused by physical conditions or have chronic health conditions which may directly affect their mental or emotional status. Would you agree that it takes special training and experience in dealing with the mental health needs of the elderly? To what extent has the profession, and the field generally, developed special expertise in geriatric psychology? Is there an accrediting body? How many persons hold themselves out as geriatric specialists?

Dr. LEVITT. The issues included in your question are both fascinating and complex. The area of geriatric mental health has been the object of considerable study within psychology for many years. A good deal of clinical research has given us new insights both about the aging process and about the relevance of psychological interventions to the aged population. One very important fact we have so far discovered is that the elderly do not become different psychological people once they reach age 65, rather they are at a different developmental stage from those persons age five, 15, or 45. Therefore, we believe that some part of the push toward specialization of services and therapeutic approaches for the elderly may be inappropriate. We do not deny that many of the elderly are unusually susceptable to combinations of problems involving medical, psychological, social and financial areas of their lives. In consequence, it is entirely appropriate tha specialized training programs are being developed to train practitioners for responding to these multiple and crosscutting needs. However, segregation of the elderly may not be the best approach.

There is a recognition by the National Institute of Mental Health that psycholgists are the most active of the mental health disciplines in the area of aging. There are currently four specialized doctoral training programs in geriatric psychology. However, we have not been satisfied that we are doing enough even yet. We are promoting the inclusion of geriatric mental health course work in all doctoral training programs so as to help educate psychologists to the differing needs of the nation's elderly.

The American Psychological Association was the prime mover in holding a Mini-Conference on the Mental Health of Older Americans in conjunction with the 1981 White House Conference on Aging. Additionally, the APA held a Conference on Training Psychologists for Work in Aging in 1981, and we have received a grant from the Retirement Research Foundation to carry on the work of that Conference.

In short, the discipline of psychology has been as active as any health profession in working to assess and meet the needs of elderly Americans.

Your other question about the combination and interaction of mental and physical problems in the aged opens up an extremely valuable point for discussion and consideration by the Committee. Psychologists have been trying for many years to expand the practitioner pool available to this nation's elderly, and expand Medicare coverage of mental health services for just exactly the reasons mentioned in your question. That is: the interaction of medical problems and psychological problems present a clear need for trained practitioners in each. At present, Medicare beneficiaries are unable to receive competent mental health care unless their problems can be dealt with by a psychiatrist within an extremely brief period of time. Unfortunately, psychiatrists are not available to many, many of the nation's elderly, and therefore mental and emotional problems are brought to non-psychiatric physicians where they are too-often treated inappropriately or not at all.

I will not suggest that no non-psychiatric physician is competent to treat mental health disorders (as I would not suggest that no specialist in dermatology is competent to set broken bones) but to preclude the participation of fully-trained mental health specialists in the delivery of mental health services covered under Medicare,

**while allowing untrained physicians to deliver and charge for mental health treatment, is dismally poor policy. It is for the correction of past mistakes, and the creation of a better future, that I urge adoption of H.R. 6092.**

Chairman JACOBS. Ms. Casber.

Ms. CASBER. I would like to inquire of anyone on the panel, most of you mentioned the fact that the charge per patient visit is less for both psychologist and clinical social workers than for psychiatrists.

However, there are two arguments made in response to that. I would like to know what you would say to those arguments, and that is that the services while cheaper on a per unit basis would be additive, reimbursed by medicare and would be added, not substitute services.

The other is that the CHAMPUS study would show potential savings from use of clinical social workers rather than psychiatrists which also seems to show that reimbursement of clinical social workers can cause, will cause an increase in the price of the costs of clinical social workers.

Would you respond to those two comments?

Mr. ADAMS. I would appreciate an opportunity to respond to the second, although I am not sure it is the more important.

I think it is the one where there has been more misunderstanding.

As you may know, Mr. Chairman, I addressed a letter to the subcommittee last week on a different aspect of the CHAMPUS demonstration project on clinical social work services, because the second interim report was misleading, and they acknowledged that it was erroneous and misleading with respect to some of the aspects of the fee structure of clinical social workers versus psychiatrists.

That was clarified by CHAMPUS in their third interim report in table 5. I provided that to the subcommittee. You may wish to include that in the hearing record.

I am not aware of any indication thus far in what I have seen of the CHAMPUS study that indicates that they found any change in the fee structure as a result of the demonstration project. Unless there is a new report I have not seen.

I think the suggestion about additive services versus replacement services, that is something that we will see in these demonstration projects. I would have to say that the professions would certainly hope and expect that there would be some additional utilization. That is part of what we have been talking about today. The restrictive provisions have meant that you are not providing service to the people who Congress said they intended to provide service to.

I think it is somewhat dishonest to say we are covering the service, but on the other hand structure the delivery in a way that most people cannot get it. If the answer is we cannot afford to give it to everybody, then give everybody less of it. But I don't think Congress intended that.

The relevant question I think is on an overall program basis—that is why I am disappointed we don't have more in front of us to look at from both CBO and HCFA in terms of cost estimates—but from an overall program standpoint as we say in the National Federation's prepared testimony, there is good reason to suspect and believe that whatever additional costs is caused by what we hope will be increased service and utilization, will be offset in whole, or in part, and the answer is no one has any real precise knowledge of that one way or the other, but there is lots of good evidence that there will be offsetting cost savings elsewhere in the system, such as the examples that Marsha Wineburgh gave where medicare paid for and would have paid more for hospital and physician costs which turned out to be unnecessary.

Mr. **Burch**. My comments are that currently within my center all my costs are obviously being covered from some source so that the total cost package would not increase by permitting us to cover other providers independently.

I think what we have going on currently is—I am sure you have heard this many times—a shift in where the costs end up.

Even a more serious problem in Indiana is the way our medicare is being administered. Mr. Chairman, the problem is the restriction of what is covered. The term "outpatient" is so narrow that the State only covers active treatment, and "active treatment" is so narrowly defined that virtually no dollars are coming into our system right now for outpatient mental health care on an outpatient basis.

It looks to us that active treatment is getting so narrowly defined that a patient must become psychotic, must be hospitalized, and must be treated by a physician for any dollars to flow into our system from medicare. I think that that is very, very restrictive.

So, although I support this bill, even if we had it in Indiana right now, there are restrictions; they are so narrowly defining active treatment that it is, frankly, over the short run, something that won't even help.

The other thing I think happens is that when folks under medicare find out the services are not going to be covered in the mental health side of the system, they then go to a general practitioner who hospitalizes them under a medical diagnosis even though the primary problem we are dealing with is one of psychogenic origin, and it gets treated on the general health side under some other guise.

So, again, there is a different kind of cost shifting but the costs are there, and someone is going to bear them either on the mental health systems side or general health systems side. Therefore I would be surprised if by including these additional folks whether or not we would be increasing total health care.

Mr. **Martin**. Mr. Chairman, we, too, would be concerned about the CHAMPUS figures, the original executive summary is totally-misleading. It adds apples and oranges. It adds up 25-minute sessions and 50-minute sessions indiscriminately and divides by the total number of providers, and those numbers have been corrected by CHAMPUS as they well should be.

On page 11 of our written testimony, Mr. Chairman, we have broken down the cost for the four most common therapies used and we show a substantial cost savings by using psychologists in those categories.

We are presently working with the CHAMPUS computer to produce a more exhaustive list and with the Chair's permission and on reviewing the material, and we hope to get it to the committee in a few weeks, we would like to have it put in the record at this point if it is not too voluminous.

Chairman **Jacobs**. Without objection, it will be included.

[The information follows:]

December 1982

## APA Reanalysis and Correction of CHAMPUS User's Guide for Psychiatric Reports (July 1982)

In July 1982 the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) released summative findings which many have mistakenly interpreted as showing that psychologists charge more for theapeutic services than psychiatrists. In fact, psychologists charge less for their services. There has been considerable discussion and controversy since the release of the CHAMPUS figures. This memo will discuss how the comparison error was made, present a reanalysis of the treatment data, and briefly discuss the new findings.

The data was presented in a way that made it appear that psychologists and psychiatrists were being compared on a cost-per-visit basis. While it was not the intention of CHAMPUS to make this comparison, their manner of data presentation encouraged the comparison and misinterpretation of the cost figures. The damaging aspect of the CHAMPUS presentation is that rumors were started that psychologists charge more for treatment than psychiatrists, and accusations made that psychologists are trying to manipulate the data to reduce the impact of the figures. These rumors are proving difficult to correct.

The original comparison error was made in a document titled the User's Guide for Psychiatric Reports for Care Provided Under the CHAMPUS Program in Fiscal Year 1980, where tables presented cost-per-visit data from psychologists, psychiatrists, and other practitioners in a way which suggested that psychologists on an average charge more per therapeutic visit than psychiatrists. However, the data presented was a mismatch of procedural codes and did not account for variations in type or length of treatment service. For example, Table 12 of the User's Guide presented the most frequently used procedures for each practitioner and the average amount paid per outpatient visit. The practitioners' procedural codes and average cost per visit were presented as follows:

| Type of Practitioner | Procedural Code No. | Description | Average Amount Paid Per Visit |
|---|---|---|---|
| Psychiatrists | 90805 | Psychotherapy - verbal, 50 min. | $50.82 |
| Psychologists | 92803 | Psychotherapy, adult or child, 45-50 minutes, in office | $55.75 |

An APA reanalysis of the CHAMPUS cost data, completed in December 1982, using identical procedural codes for each practitioner, presents a more accurate comparison of average cost per visit claims:

| Description | Procedural Code | Type of Practitioner | Average Paid |
|---|---|---|---|
| Psychotherapy, verbal, 50 minutes (outpatient) | 90805 | Psychiatrist | $50.82 |
| | | Psychologist | $47.51 |
| Psychotherapy, adult or child, 45-50 minutes (outpatient) | 92803 | Psychiatrist | $57.58 |
| | | Psychologist | $55.75 |

A comparison of the data in this manner, using identical treatment codes and length of treatment session for each of the two professions, shows that for these procedural codes psychologists charge less per treatment visit than do psychiatrists. A further comparison of CHAMPUS mental health claims yields consistent results.

Table 1 presents CHAMPUS inpatient mental health service claims by procedural code comparisons. A comparison of the therapeutic session cost data allows the following conclusions: 1) for each of the three individual treatment categories psychologists charge less per session than psychiatrists;

2) for the two Group treatment categories psychologists charge less per session than psychiatrists; and 3) for the Family treatment category psychologists charge less per session than psychiatrists.

Table 2 presents CHAMPUS outpatient mental health service claims by procedural code comparison. A comparison of the therapeutic session cost data allows the following conclusions: 1) for two of the three Individual treatment categories psychologists charge more per session than psychiatrists; 2) for the two Group treatment categories psychologists charge less per session than psychiatrists; and 3) in the Family treatment category psychologists charge less per session than psychiatrists.

In the two Individual treatment categories where psychologists do charge more than psychiatrists per session visit, the total percentage of claims represented are very small (2.3% and .11%) compared to the first Individual treatment category, and the total dollar amounts relatively insignificant.

Although the differences in charges between psychologists and psychiatrists are not great, these differences could have a significant impact on overall CHAMPUS (or Medicare/Medicaid) charges when applied to the total beneficiary population.

## TABLE 1

## CHAMPUS INPATIENT MENTAL HEALTH SERVICES CLAIMS
## CONTROLLED COMPARISONS: SESSION LENGTH BY SESSION TYPE
## SOURCE: CHAMPUS CLAIMS REPORT # 1; JULY, 1982
## RE-ANALYSIS: AMERICAN PSYCHOLOGICAL ASSOCIATION; JANUARY, 1983

| TREATMENT CODES | DESCRIPTION | PSYCHIATRIC | PSYCHOLOGICAL |
|---|---|---|---|
| 90801 90802<br>90805 90809<br>90854 92803<br>92804 92805 | Individual<br>Treatment<br>45-60 minutes | N 105355<br>M $56.85<br>T 46% | N 3508<br>M $51.29<br>T 48% |
| 90806 90856<br>92806 92807<br>92808 | Individual<br>Treatment<br>20-30 minutes | N 79279<br>M $32.10<br>T 34% | N 1102<br>M $27.61<br>T 15% |
| 90803 90804 | Individual<br>Treatment<br>15-20 minutes | N 15931<br>M $20.63<br>T 7% | N 104<br>M $17.77<br>T 1.4% |
| 90811 90858<br>92815 92816<br>92821 92822 | Group Treatment<br>45-60 minutes | N 8204<br>M $21.64<br>T 3.6% | N 190<br>M $18.22<br>T 2.6% |
| 90810 90859<br>90861 92817<br>92818 92823<br>92824 | Group Treatment<br>90-120 minutes | N 2211<br>M $29.91<br>T 0.96% | N 111<br>M $28.57<br>T 1.5% |
| 92831 | Family Treatment<br>45-50 minutes | N 460<br>M $66.85<br>T 0.20% | N 49<br>M $64.49<br>T 0.68% |
| 90839 90892<br>92841 | Psychological<br>Testing[1]<br>60 minutes | Not Applicable | N 1636<br>M $59.24<br>T 22.5% |
| Total Percentage[2] | | 91.65% | 92.50% |

[N] Total number of claims used in subgroup.
[M] Estimated average cost per claim for subgroup.
[T] Percentage of total number of claims submitted by practitioner type.
[1] Psychological testing is included to show the percentage of inpatient claims for testing services submitted by psychologists.
[2] Percentage of total number of claims used in all comparisons, including psychological testing.

## TABLE 2

## CHAMPUS OUTPATIENT MENTAL HEALTH SERVICES CLAIMS
## CONTROLLED COMPARISONS: SESSION LENGTH BY SESSION TYPE
SOURCE: CHAMPUS CLAIMS REPORT # 2; JULY, 1982
RE-ANALYSIS: AMERICAN PSYCHOLOGICAL ASSOCIATION; JANUARY, 1983

| TREATMENT CODES | DESCRIPTION | PSYCHIATRIC | PSYCHOLOGICAL |
|---|---|---|---|
| 90801 90802<br>90805 90809<br>90854 92803<br>92804 92805 | Individual Treatment 45-60 minutes | N 288543<br>M $53.57<br>T 78% | N 213951<br>M $52.51<br>T 82% |
| 90806 90856<br>92806 92807<br>92808 | Individual Treatment 20-30 minutes | N 39266<br>M $31.33<br>T 11% | N 6048<br>M $32.13<br>T 2.3% |
| 90803 90804 | Individual Treatment 15-20 minutes | N 6226<br>M $18.89<br>T 1.7% | N 276<br>M $19.29<br>T 0.11% |
| 90811 90858<br>92815 92816<br>92821 92822 | Group Treatment 45-60 minutes | N 9490<br>M $23.26<br>T 3.6% | N 2013<br>M $22.34<br>T 0.80% |
| 90810 90859<br>90861 92817<br>92818 92823<br>92824 | Group Treatment 90-120 minutes | N 8019<br>M $25.83<br>T 0.96% | N 6160<br>M $25.44<br>T 2.4% |
| 92831 | Family Treatment 45-50 minutes | N 2424<br>M $68.40<br>T 0.66% | N 10539<br>M $65.55<br>T 4.1% |
| 90839 90892<br>92841 | Psychological Testing[1] 60 minutes | Not Applicable | N 11245<br>M $55.10<br>T 4.3% |
| | Total Percentage[2] | 96.15% | 92.05% |

[N] Total number of claims used in subgroup.

[M] Estimated average cost per claim for subgroup.

[T] Percentage of total number of claims submitted by practitioner type.

[1] Psychological testing is included to show the percentage of outpatient claims for testing services submitted by psychologists.

[2] Percentage of total number of claims used in these comparisons, including psychological testing.

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## Table 12. Most Frequently Used Procedures for Each Type of Practitioner and Average Amount Paid per Visit (Outpatient Professional Services - Report 2)

| ype of titioner | Procedural Code No. | Description | Frequency | Percent of Total Procedures* | Average Amout Paid Per Visit |
|---|---|---|---|---|---|
| nding icians | 92803 | Psychotherapy, adult or child, 45-50 minutes, in office | 14,417 | 30.9% | $49.73 |
| hiatrists | 90805 | Psychotherapy - verbal, 50 minutes | 163,608 | 44.4 | 50.82 |
| hologists | 92803 | Psychotherapy, adult or child, 45-50 minutes, in office | 129,562 | 49.8 | 55.75 |
| al Workers | 03030 | Individual Counseling | 96,448 | 55.8 | 44.77 |
| apists Types) | 90805 | Psychotherapy - verbal, 50 minutes | 62 | 75.6 | 43.47 |
| Others | 90805 | Psychotherapy - verbal, 50 minutes | 47,498 | 59.9 | 43.24 |

ercentages are based on the total number of psychiatric visits provided by the type of ractitioner indicated in Column 1.

Mr. **Martin**. On the question of the additive service, I would like to call the Chair's attention to the recent article in Psychiatric News, in which a staff at a major teaching hospital was given an examination as to their ability to recognize psychological and psychiatric problems.

In summarizing the results of this examination, it was discovered that physicians not trained in mental health flunked 88 percent of the time, 77 percent of the time, 88 percent of the time, 69 percent of the time.

I would like permission to introduce that into the record at this point, Mr. Chairman.

Chairman **Jacobs**. Without objection.

[The information follows:]

PSYCHIATRIC NEWS
November 5, 1982 pp.24,29

# Internal Medicine Residents Shown Lacking In Knowledge of Psychiatry

Internal medicine housestaff at a major teaching hospital have demonstrated substantial and perhaps dangerous gaps in their knowledge of psychiatric disorders and treatments, according to a recently completed study. Further, residents with more extensive training did not demonstrate greater amounts of psychiatric knowledge than did first-year residents.

The researchers, surprised by the findings, said that these knowledge deficits were "of a degree that seems likely to impair [residents'] capacity to care adequately for many of their patients."

These findings are based on an oral examination developed at the University of Alabama, Birmingham, by Steven A. Cohen-Cole, M.D., to assess "realistic knowledge requirements for primary medical care." They were reported in a recent issue of *General Hospital Psychiatry*.

Armed with decades of studies showing high incidences of psychiatric illnesses among medical patients, Cohen-Cole and his colleagues decided to evaluate how well equipped internal medicine and primary care residents were to manage four of the most commonly presenting psychiatric disorders: delirium, dementia, depression, and psychogenic pain.

The oral examination consisted of two case-management problems accompanied by 19 standardized, open-ended questions and was presented simultaneously on an audiotape and a printed transcript. After each question, standardized follow-up probes were asked until the examinee indicated that he or she had nothing more to add. Twenty-six residents from the primary care and traditional internal medicine residency programs participated—11 from PG-1, eight from PG-2, and seven from PG-3.

All responses, after being transcribed, were rated independently by three of the article's authors: Julian Bird, M.R.C.P., visiting professor of psychiatry; Arthur Freeman, M.D., professor and vice-chairman of the psychiatry department; and Jack Hain, Ph.D., professor of psychiatry. To maximize interrater reliability, guidelines and illustrative answers were developed. Guidelines were based on the concept of "what an internist needs to know in conducting his or her day-to-day practice."

The first case problem described an elderly woman admitted to the hospital with pneumonia and symptoms designed to indicate "acute delirium together with strong clues that this was superimposed upon depression and dementia." After the pneumonia improved she was confused, hallucinating, paranoid, and difficult to manage; prior to admission, she had become withdrawn, decreased her caloric intake, and lost interest in her appearance.

The second case involved a 33-year-old man with chronic abdominal pain that, after an extensive physical examination, was determined to be psychogenic. His description indicated low self-esteem, inability to express anger, and conflicts with authority figures, particularly his father. "He missed a lot of work, demanded 'strong' pain medications, and missed a doctor's appointment after the doctor told him, just like his father did, 'to return to work in spite of his pain.' "

Out of a possible score of 57, the median was 32.50; the highest score obtained was 41, the lowest, 21. In addition to a failure of more experienced residents to achieve higher scores, the authors reported no differences between primary care residents and those specializing in internal medicine.

In response to the first case, for example, only four residents (15 percent) could make the three correct diagnoses; most often the acute organic problem, that is, delirium, was overlooked. When asked to identify signs that discriminated between organic and functional mental disorders, 88 percent named fewer than three, though five such signs were provided in the case report.

Regarding the case of the man with chronic pain, 92 percent of the examinees failed to describe as part of treatment an approach to refuse prescribing narcotics in response to the patient's escalating demands for them. When asked to provide reasons for refusing to give narcotics in such a case, 46 percent responded only "it's not medically justified."

In summarizing the most interesting of their findings, Cohen-Cole and his colleagues stated that "the great majority of [participating] housestaff could *not a)* list three factors to help distinguish organic from 'functional' psychosis (88 percent); *b)* describe an adequate dose and frequency of antipsychotic medication (77 percent); *c)* mention extrapyramidal side effects and drug dosage to control them (85 percent); *d)* list three psychosocial interventions for agitated delirium (88 percent); *e)* list three additional signs of depression (69 percent); *f)* describe three basic interventions for depression (81 percent); *g)* outline a satisfactory antidepressant schedule (85 percent); *h)* list three side effects of antidepressants (88 percent); *i)* describe three approaches to 'psychogenic' pain (88 percent); *j)* provide an adequate therapeutic rationale for avoiding opiate analgesics in 'psychogenic' pain (92 percent); or *k)* describe any anger (or frustration) on the part of [the male case study] (70 percent) to explain a missed appointment."

The authors applied their findings, reported in the journal's July issue, to the development of a needs-based liaison psychiatry curriculum at the University of Alabama that stresses diagnosis and treatment of the common psychiatric disorders dealt with in their study. The oral examination used as the study instrument will be administered again at the end of the newly designed program to gauge its impact on the primary care residents.

Mr. **Martin**. I think what we will find is that these services are not additives indeed, they are proper services, properly rendered and substituted for irrelevant services that are being rendered by hospital staffs and by independent providers who are not trained to recognize mental health problems.

Let me say if I may, Mr. Chairman, I am really quite upset with HCFA. 1833(c), which provides for payment for mental and emotional disorders, is sui generis, there is no article like that within the——

Chairman **Jacobs**. I like that pronunciation.

Mr. **Martin**. There is nothing in the code for that. It should be easy to isolate precisely what they are paying for in mental and nervous disorders, and they don't know.

They gave us figures saying that they put out $70 million in 1978 which is the last year for which they could give those figures, 70 million for outpatient care by psychiatrists and psychologists, and 150 million for in-patient care for mental and nervous disorders. That is $185 million.

I cannot believe even with the increases in costs since then, that $20 million, you are talking about 10 percent of the program, is going to be increased by that much and that does not take into consideration all of the evidence you have is that the mental health services decrease costs. There is not one study published that says they increase costs. I hope the subcommittee asks HCFA to introduce into the record the assumptions on which these estimates were based on and some of the raw data. We would like to know.

We never get to see it. They come up with numbers right off the bat and every time they are different, and we never see the assumptions on them and we don't know exactly what their figures are and whether they have set-offs in them or not.

That would be appreciated.

[Subsequent to the hearing Mr. Gradison submitted the following questions:]

*Question 1.* You stated before the Committee your disagreement with administration estimates that H.R. 6092 would increase costs particularly in view of all the evidence that mental health services decrease cost. OTA in a report to the Congress in 1980 on the efficacy and cost effectiveness of psychotherapy concluded that their review suggests for some type of treatment and for some problems, psychotherapy appears to be cost effective but that the findings must be considered tenuous. What is needed, according to OTA "is a more systematic application of rigorous research designs that employ no-treatment and placebo treatment conditions as well as more comprehensive measures of outcome and costs."

In 1979, the former Chief of the Alcohol, Drug Abuse and Mental Health Administration, Dr. Gerald Klerman, challenged the profession to prove the efficacy of their services.

Do you have new data that would refute OTA's conclusion or meet Dr. Klerman's challenge?

Mr. **Martin**. The final paragraph in the summary chapter of the same Office of Technology Assessment report that you cite ("Background Paper #3: The Efficacy and Cost Effectiveness of Psychotherapy" October, 1980) reads as follows:

"In summary, OTA finds that psychotherapy is a complex—yet scientifically assessable—set of technologies. *It also finds good evidence of psychotherapy's positive effects.* Although this evidence may not be generalizable to the wide range of problems for which therapy is employed, it suggests that additional research may provide data useful for the development of mental health policy. Given the potential net benefits of psychotherapy, this effort would seem to be justified." (emphasis added)

I believe that this statement better represents the true findings of OTA on psychotherapy—and places psychotherapy among other health care "technologies" that have been found to be safe, effective and appropriate when used by trained practitioners. Rational analyses from all sources agree that psychologists are among the best trained and most qualified practitioners of psychotherapy.

The statement from the Office of Technology Assessment which you quote is, in my opinion, simply an example of the typical scientist's reticence to express conclusions in terms of absolutes. The phrase "more research is needed" is virtually a requirement in any scientific research report. In a massive research project sponsored by the Alcohol, Drug Abuse and Mental Health Administration entitled "Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization" (published in Medical Care, Vol. 17, No. 12, December 1979), former ADAMHA Administrator, Gerald L. Klerman, M.D., states:

"The analytical review of the literature presented here is the most comprehensive attempt yet undertaken . . . around the question of whether treatment of alcoholism, drug abuse or mental illness causes a subsequent reduction in treatment for other health disorders. As you will see, the studies are almost unanimous in finding that there is such a reduction."

However, as a good scientist, Dr. Klerman adds that he looks forward to "more rigorous research in this area."

You may be interested in the recent conclusions of Dr. David Banta, Assistant Director of the Office of Technology Assessment for Health and Life Sciences, regarding the OTA report on psychotherapy. (Dr. Banta was the supervisor of the medical technology analysis by OTA). He states:

"For the Congressional audience, probably the most important section of the report was the substantive review of the literature on psychotherapy outcomes. Because of the plethora of studies, the report focused on several prominent reviews of the psychotherapy literature and commentary generated by these reviews. In assessing the implications of the reviews, the central finding was that, despite important differences in the studies included and the criteria for assessing psychotherapy, all reports provided some evidence of psychotherapy's effectiveness (Parloff, 1979; Smith, Glass, and Miller, 1980; VandenBos & Pino, 1980). This finding is stronger for more recent literature. Moreover, there is little evidence of lack of efficacy of psychotherapeutic treatments. The report found that the evidence is more supportive of the efficacy of psychotherapy than other explanations, such as spontaneous remission or placebo effects. At the very least, the literature indicates that the promise of psychotherapy is still high and implies that a systematic research program linked to particular policy decisions would be potentially useful."

(H. David Banta, M.D., M.P.H. and Leonard Saxe, Ph.D., "Reimbursement for Psychotherapy: Linking Efficacy Research and Public Policy-Making, "American Psychologist, in press).

I have re-read the statement of Dr. Saxe who testified before this Subcommittee on December 14, 1982 and I believe he, too, reaffirmed the efficacy of psychotherapy.

While I do not argue with the proposition that all forms of treatment should be scientifically tested for safety, efficacy and appropriateness, it concerns me that mental health therapies are seemingly being singled out for intense study prior to recognition by Medicare. Psychological care has been an integral part of virtually every health care financing program for many years—including every federal financing program except Medicare. You may find it interesting to note that main document on medical technologies, for which the Background Paper #3 on Psychotherapy was an addendum, includes the following statement:

"It has been estimated that only 10 to 20 percent of all procedures currently used in medical practice have been shown to be efficacious by controlled trial" (Office of Technology Assessment, Assessing the Efficacy and Safety of Medical Technologies, Washington, D.C.: GPO, 1978, p.7)

In spite of such findings, Congress has chosen not to extend the life of the National Center of Health Care Technology. I fail to understand why Congress is not concerned with efficacious tests on surgical and other physically intrusive medical practices but continues to be apprehensive about psycotherapy.

In response to the other part of your question, I offer two relatively new items of evidence about the effectiveness and cost-effectiveness of psychological care.

The first is a research report by Richard L. Graves and Janice L. Hastrup entitled "Psychological Intervention and Medical Utilization in Children and Adolescents of Low-Income Families." This research report does respond to your concerns about the effectiveness and cost-effectiveness of psychotherapy. The abstract for the report states:

"The present investigation studies the effect on medical utilization when psychological care was provided to a sample of children and adolescents whose low-income families were members of a completely subsidized health program. Comparisons of medical visits were made over a 2-year period for three groups: a treatment group of registrants receiving psychological services; a control group matched with the treatment group according to age, sex, ethnicity, as well as medical utilization and psychological distress; and a group matched only by age, sex, and ethnicity. Results indicated that registrants who received psychological treatment had significant decreases in overall medical utilization, whereas there was no decreases in the other two groups. These findings are consistent with earlier research but extend the pattern of results into younger populations as well as low-income families."

Importantly, the authors conclude: "Psychological services within a health plan not only decrease excessive medical utilization by some members but also meet patient needs not addressed by the medical service." I offer a copy of the Graves and Hastrup report for the record.

The second new piece of evidence comes from the City Manager of Redondo Beach, California—an individual who, personally and professionally, has no vested interest in psychological services or their provisions. In Timothy J. Casey's article in the June, 1982 Personnel Journal, he outlines the longterm effects of retaining a group of psychologists to provide mental health care for city employees. City policy was developed to promote referrals to this California Psychological Health Plan (CPHP) so as to possibly reduce overall health care expenditures. Casey states:

"Recent state and national studies have suggested that between 50 and 80 percent of complaints heard by physicians either have no organic base or have a significant emotional component to them. As such, continued treatment by a physician generally does not contribute to the resolution of the problem and adds unnecessarily to the raising cost of health care."

Therefore, the city of Redondo Beach, California sought out greater use of psychological services by their city employees to deal directly with this problem. The City Manager's research results were: "the period of time during which CPHP has been a part of Redondo's health benefit program has paralleled an unusally stable experience under the regular group medical plan. The stablization of health insurance premiums and the generation of a sizeable dividend reserve had already been mentioned. Budget savings are estimated at more than $200,000 during the past three years, thereby freeing scarce financial reserves for appropriation to other programs and projects."

Significantly, Casey adds the following sentence: "Another interesting trend during the same period was a drop in the rate of absenteeism due to sickness, from 3.0 to 1.6 percent."

I offer a copy of Mr. Casey's article for the record.

*Question 2.* If the expansion of reimbursement for mental health services saves money why have payors such as Blue Cross, Aetna and CHAMPUS subsequently reduced coverage or placed limits on the amount of reimburseable services after a few years of experiences with expanded reimbursement?

Mr. MARTIN. Limitations have frequently been necessitated by economic factors in the private sector that are not applicable to Medicare. In some jurisdictions, insurance companies offering comprehensive mental health coverage found themselves as the only insurance program offering such comprehensive coverage and suffered from what the economists call adverse selection. That is, every one in need of a particular coverage moves to the plan that provides the best reimbursement for that coverage, putting one company in jeopardy for all reimbursement. Since Medicare is not a competitive plan but rather is a universal plan, adverse selection would not be a problem.

Unfortunately, most insurance programs do not collect the types of data that would allow them to accurately monitor cost and utilization, and thus make less than educated decisions about coverage. Therefore, when mental health utilization goes up, the insurance programs become worried and cut benefits. We expect mental health benefits to be used—the need for those services has been well documented by both governmental and private sources. However, a demand for vital services does not necessarily mean overutilization, it means that a need is being met. The current demand for chemotherapy services for cancer does not necessarily mean overutilization, nor does the current demand for mental health therapy.

However, since the vast majority of insurance programs do not collect comprehensive data on their costs and utilization, they are not aware that their medical costs are extremely likely to be reduced significantly and permanently through treatment of psychological disorders. One of the few private health insurance programs that does collect comprehensive data is Blue Cross of Western Pennsylvania. That program found that inclusion of mental health benefits resulted in a significant reduction in medical utilization, and thus a significant reduction on overall costs. The four-year study showed that, as could be predicted, mental health costs increased somewhat when mental health benefits were included—but that medical care costs were dramatically decreased in this same group. The reduction in total costs per patient was 31 percent. Clearly this level of reduction is something to be very seriously considered for its implications for the Medicare program.

The experience of the CHAMPUS program with psychiatric benefits costs that led that program to seek reductions in coverage was with inpatient care. The current Congressionally-imposed cap in inpatient psychiatric benefits (60 days unless a peer review program indicates a need for more hospitalization) is an effort to keep those inpatient costs within reasonable limits. Psychologists advocate most strongly for outpatient care—which has been shown to be both a more effective and a more cost-effective form of patient care. I offer for your information an article on the relative merits of inpatient care and outpatient care written by Dr. Charles Kiesler, and ask that it be included for the record.

*Question 3.* I understand that H. R. 6092 could potentially add as many as 65,000 practitioners who could bill on a fee-for-service basis under Medicare. Can you explain how adding that many new fee-for-service practitioners to the program could end up decreasing costs particularly in view of the lack of data to support the cost effectiveness of such services in the fee-for-service setting where most of the additional services would be provided?

Mr. MARTIN. The addition of trained and qualified mental health care specialists to diagnose and treat mental and emotional disorders would be an important step in providing proper mental health care to the Medicare population. It is agreed by virtually every source that non-psychiatric physicians have little or no training or demonstrated competence in recognizing, diagnosing or treating psychological disability. Therefore, by allowing psychologists to deliver services under Medicare, you will have acted to reduce the wasteful and inappropriate non-treatment of Medicare beneficiaries by general practice physicians. The provision of appropriate treatment in the first place will help to save money.

Also, it has been shown that non-physician mental health care practitioners have lower charges than do physician practitioners. Data available from the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) indicated that psychologists charge less than do psychiatrists—as we noted in our testimony. It is unfortunate that the reports from CHAMPUS were misleading in the impressions they give, but a simple analysis of the data indicated that for identical treatment procedures, psychologists consistently charge less. These lower fees will help to save money.

In addition, the "offset" function of mental health services—where appropriate use of mental health services by those in need significantly reduces utilization and cost of medical care services—has been documented again and again in studies over the past several decades with various treatment populations in many parts of the country, and in other countries. There is absolutely no reason to presume that this offset function would not occur in fee-for-service settings, since the basic reason that it occurs is the diminution of psychological distress—a distress that otherwise is exhibited in such ways as chronic headaches and backaches, stress-related problems on the job and with the family, alcoholism and drug abuse, intestinal disorders such as ulcers and colonic disturbances, arthritis-like pain and disability, asthmatic disorders, insomnia and other sleep disturbances, high blood pressure and other cardiovascular disorders, significantly higher susceptibility to infections, and prolonged recovery periods from disease and surgery. These are health problems that are often treated by medical doctors with drugs and surgery—in a futile effort to relieve symptoms. The sad fact is that medical intervention is often neither appropriate nor effective—and medical interventions in these cases is a waste of funds.

Treating these forms of psychological distress appropriately and effectively will help to save Medicare dollars.

*Question 4.* In order to control expenditures and prevent abuses, the Congress in approving payment for physical, occupational and speech therapy services included a requirement that payment for these services may not exceed a reasonable salary equivalency. Would not such an approach with respect to mental health practitioners make the services available to the elderly on a less costly but nonetheless reasonable basis?

Mr. MARTIN. At present we do not know enough about the "reasonable salary equivalency" approach to cost containment to give a complete answer. In theory, we would have no opposition to cost containment systems that are equitable both to patients and practitioners, are applied without discrimination to both mental health services and to physical health services, and that do not interfere with the provision of necessary health care services. In general, we would prefer a cost containment approach to mental health services that emphasized the use of fully-trained mental health professionals, rather than untrained general practice physicians, to deliver the most competent, effective, and therefore cost-effective services.

*Question 5.* Would you support the application of a reasonable salary equivalency to mental health services reimbursement?

Mr. MARTIN. I don't know. It would depend on many factors I mentioned in my previous answer.

*Question 6.* You indicated that the CHAMPUS data is totally misleading and is being corrected. Committee staff verified the attached CHAMPUS data with program officials and confirmed that for outpatient psychotherapy of 50 minutes duration the average amount paid per visit to psychiatrists in fiscal year 1980 was $50.82. For psychologists, in fiscal year 1980 the average amount paid per 45–50 minute visit for psychotherapy was $55.75. Staff was told that the data are correct and no changes are being made.

I wanted to clarify this matter for the record and would appreciate having for the record the corrected data you referred to.

Mr. MARTIN. I urge you to review the CHAMPUS table with a critical eye. You will note that it is entitled "Most Frequently Used Procedures for Practitioner and Average Amount Paid Per Visit." You will also note that the listing for "Psychiatrists" and that for "Psychologists" refer to different Procedural Codes. Therefore, although the table does, in fact, represent valid data, the sense it conveys is entirely wrong. A comparison of non-identical Treatment Codes (with similar descriptions) leads to an invalid analysis.

The American Psychological Association has re-analyzed the CHAMPUS data, and has compared identical treatment codes. Our tables clearly show that psychologists charge less for their services than do psychiatrists in nearly every procedure. In our testimony, we included a partial listing of that reanalysis. I submit two more tables for your information, and ask that they be entered for the record.

The CHAMPUS report from which your table is taken represents extremely sloppy work. As the product of a statistical branch of a major federal agency, this report is indefensible. The fact that a statistical report would convey to most readers an entirely incorrect conclusion suggests malfeasance of a high degree. The fact that your staff was unable to receive the correct interpretation of the CHAMPUS report from CHAMPUS staff severely undermines the trust that federal agencies and Congressional Liaison Offices must earn. I am sure that such a mis-analysis would not be acceptable if performed by a member of your own staff, and I hope you will be able to convey to CHAMPUS the Committee's displeasure over the unfortunately incorrect impressions that the statistical report has given.

## TABLE 1

## CHAMPUS INPATIENT MENTAL HEALTH SERVICES CLAIMS
## CONTROLLED COMPARISONS: SESSION LENGTH BY SESSION TYPE
## SOURCE: CHAMPUS CLAIMS REPORT # 1; JULY, 1982
## RE-ANALYSIS: AMERICAN PSYCHOLOGICAL ASSOCIATION; JANUARY, 1983

| TREATMENT CODES | DESCRIPTION | PSYCHIATRIC | PSYCHOLOGICAL |
|---|---|---|---|
| 90801 90802<br>90805 90809<br>90854 92803<br>92804 92805 | Individual<br>Treatment<br>45-60 minutes | N 105355<br>M $56.85<br>T 46% | N 3508<br>M $51.29<br>T 48% |
| 90806 90856<br>92806 92807<br>92808 | Individual<br>Treatment<br>20-30 minutes | N 79279<br>M $32.10<br>T 34% | N 1102<br>M $27.61<br>T 15% |
| 90803 90804 | Individual<br>Treatment<br>15-20 minutes | N 15931<br>M $20.63<br>T 7% | N 104<br>M $17.77<br>T 1.4% |
| 90811 90858<br>92815 92816<br>92821 92822 | Group Treatment<br>45-60 minutes | N 8204<br>M $21.64<br>T 3.6% | N 190<br>M $18.22<br>T 2.6% |
| 90810 90859<br>90861 92817<br>92818 92823<br>92824 | Group Treatment<br>90-120 minutes | N 2211<br>M $29.91<br>T 0.96% | N 111<br>M $28.57<br>T 1.5% |
| 92831 | Family Treatment<br>45-50 minutes | N 460<br>M $66.85<br>T 0.20% | N 49<br>M $64.49<br>T 0.68% |
| 90839 90892<br>92841 | Psychological<br>Testing[1]<br>60 minutes | Not Applicable | N 1636<br>M $59.24<br>T 22.5% |
| Total Percentage[2] | | 91.65% | 92.50% |

[N] Total number of claims used in subgroup.

[M] Estimated average cost per claim for subgroup.

[T] Percentage of total number of claims submitted by practitioner type.

[1] Psychological testing is included to show the percentage of inpatient claims for testing services submitted by psychologists.

[2] Percentage of total number of claims used in all comparisons, including psychological testing.

## TABLE 2

### CHAMPUS OUTPATIENT MENTAL HEALTH SERVICES CLAIMS
### CONTROLLED COMPARISONS: SESSION LENGTH BY SESSION TYPE
### SOURCE: CHAMPUS CLAIMS REPORT # 2; JULY, 1982
### RE-ANALYSIS: AMERICAN PSYCHOLOGICAL ASSOCIATION; JANUARY, 1983

| TREATMENT CODES | DESCRIPTION | PSYCHIATRIC | PSYCHOLOGICAL |
|---|---|---|---|
| 90801 90802<br>90805 90809<br>90854 92803<br>92804 92805 | Individual<br>Treatment<br>45-60 minutes | N 288543<br>M $53.37<br>T 78% | N 213951<br>M $52.51<br>T 82% |
| 90806 90856<br>92806 92807<br>92808 | Individual<br>Treatment<br>20-30 minutes | N 39266<br>M $31.33<br>T 11% | N 6048<br>M $32.13<br>T 2.3% |
| 90803 90804 | Individual<br>Treatment<br>15-20 minutes | N 6226<br>M $18.89<br>T 1.7% | N 276<br>M $19.29<br>T 0.11% |
| 90811 90858<br>92815 92816<br>92821 92822 | Group Treatment<br>45-60 minutes | N 9490<br>M $23.26<br>T 3.6% | N 2013<br>M $22.34<br>T 0.80% |
| 90810 90859<br>90861 92817<br>92818 92823<br>92824 | Group Treatment<br>90-120 minutes | N 8019<br>M $25.83<br>T 0.96% | N 6160<br>M $25.44<br>T 2.4% |
| 92831 | Family Treatment<br>45-50 minutes | N 2424<br>M $68.40<br>T 0.66% | N 10539<br>M $65.55<br>T 4.1% |
| 90839 90892<br>92841 | Psychological<br>Testing[1]<br>60 minutes | Not Applicable | N 11245<br>M $55.10<br>T 4.3% |
| Total Percentage[2] | | 96.15% | 92.05% |

[N] Total number of claims used in subgroup.

[M] Estimated average cost per claim for subgroup.

[T] Percentage of total number of claims submitted by practitioner type.

[1] Psychological testing is included to show the percentage of outpatient claims for testing services submitted by psychologists.

[2] Percentage of total number of claims used in these comparisons, including psychological testing.

# Public and Professional Myths About Mental Hospitalization

## An Empirical Reassessment of Policy-Related Beliefs

CHARLES A. KIESLER *Carnegie-Mellon University*

ABSTRACT: *This article focuses on national data relevant to the following questions: (a) To what extent is mental hospitalization effective? (b) How many people are hospitalized for mental disorders yearly? (c) Has the rate of mental hospitalization been stable or rising in recent years? (d) What is the length of an inpatient episode and is it changing? (e) Has the rate of rehospitalization been rising? (f) What proportion of total hospital days are for mental disorders? The article suggests that a set of beliefs or myths about mental hospitalization exists that is not supported by national data. The national data base on mental hospitalization is surprisingly sparse, but available data suggest the following: The rate of mental hospitalization is increasing, but the place in which it occurs has changed dramatically. The length of hospital stay has been stable in most sites over the last decade; a substantial decrease has occurred in two sites, but they handle only 20% of the episodes. At least several treatment modes exist that appear to be more effective and less expensive than hospitalization. There is little evidence to support the notion of a "revolving door." Mental hospitalization is a substantial national issue: 25% of all hospital days in the United States are for mental disorders. Issues related to the need for new public policy and the difficulties in changing current policies are discussed.*

I have distinguished before between de jure and de facto national mental health policy (Kiesler, 1980). The de jure policy is that which we legislatively and collectively intend to carry out in the name of mental health. The de facto policy is that which occurs, regardless of public intent or agreement.

In the case of mental health, the distinctions between de jure and de facto policies are very important. Our national de jure policy is the development of outpatient care and deinstitutionalization. The policy of developing outpatient care, at least, has been quite successfully implemented. The National Institute of Mental Health (NIMH; 1976) reported that outpatient care had increased from 379,000 clinical episodes in 1955 to 4.6 million in 1975, a twelvefold increase over the course of 20 years. The centerpiece of this effort has been the community mental health center system, which had grown to 600 regional centers at last report. The extent to which the current executive policy (decreasing federal funds for such services and delivering the remainder of the funds in block grants to the states) will undercut this de jure policy is still unclear, but will surely be considerable. Deinstitutionalization has been more controversial, although many feel it has been clinically successful (cf. Bachrach, 1976).

However, our national de facto policy in mental health is hospitalization. NIMH reports that over 70% of mental health money is spent on hospitalization. Partly this de facto policy is due to inappropriate insurance mechanisms (cf. Kiesler, 1981a, 1981b). As the task panel on deinstitutionalization, rehabilitation, and long-term care of the President's Commission on Mental Health (Platman, 1978) said, "the level and type of care given to the chronically mentally disabled is frequently based on what services are fundable and not what services are needed or appropriate" (p. 369). Medicare, Medicaid, Blue Cross–Blue Shield, and other private insurance plans provide disincentives for outpatient care. Copayments, limits of visits, and the like for outpatient care are typically contrasted with complete coverage for inpatient care. Because of differences in the net cost to the patient, often the attending professional, the patient, and the patient's family have little choice but to choose the

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less expensive treatment. The net cost to the patient may be less for such insured inpatient care, but the total cost to the public is clearly more. Through such disincentives, the national policy of outpatient care is undercut by the practice of offering incentives for inpatient care. As a result of the paradox of this clash between policy and practice, Medicaid is quite unintentionally the nation's largest single mental health program, accounting for over $4 billion for mental health services in 1977 alone.

In the financial sense, mental hospitalization dominates our public policy. If the practice dominates the policy, it should also be a magnet for policy research. That is, policy research should focus on mental hospitalization and the de facto system that supports it. However, the policy and evaluation research literature has not given great attention to this topic. Issues of the sociology of science are very complex, but one set of inhibiting circumstances is related to the myths and stereotypes we hold about mental hospitalization. Another is the lack of integrative work across divergent aspects of mental hospitalization.

I have described the myths of mental health policy as implicit assumptions we make about what mental health and mental illness are, what the most effective treatments are given the current status of the art, and which "causes" of mental illness science will ultimately find. Our collective approach to mental health is determined by such assumptions, but the assumptions are held implicitly and seldom challenged. Partly because they are implicit, these views inhibit the effective use of knowledge and channel current and future research.

Implicit assumptions that guide a field do inhibit a continuing process of self-examination and criticism. "When our implicit assumptions are left unexamined for decades, they take on the properties of professional or scientific myths," (Kiesler, 1981a, p. 202).

The concept of stereotypes—prejudgments of what ought to be—is also applicable. One professional stereotype taken seriously is the following syllogism: serious illnesses are treated in hospitals, mental disorders can be serious illnesses, therefore mental disorders ought to be treated in mental hospitals.

I do not argue that such myths and stereotypes are ipso facto false. Indeed, many have a rather compelling intellectual quality. Rather, I feel that myths should not have a special scientific status. They should be regarded as any other scientific assumptions or hypotheses: discussed openly, tested where possible, and evaluated in light of the current state of scientific knowledge.

This article focuses on several myths and stereotypes about mental hospitalization that seem, in my experience, to be rather common among professionals and laypersons alike. Whether one should regard these as myths (or even correct beliefs) is not directly relevant to what follows. Certainly I have heard each asserted as true by professionals, by members of Congress, and by laypersons. I do not argue a priori for their truth or popularity, but only that they should be openly discussed and empirically assessed. An attempt to evaluate and integrate the empirical data on each in a single article seems worthwhile. These beliefs include the following:

1. We are putting fewer people into mental hospitals.
2. Mental hospital stays are much shorter than they used to be, and continue to decrease.
3. A "revolving door" exists such that people are staying in mental hospitals for shorter periods but are more likely to return.
4. Mental hospitalization is effective treatment for the people utilizing the service. That is, the few people we are hospitalizing are correctly placed because no alternative exists to treat them more effectively.
5. Because of the small numbers involved, mental hospitalization is a fairly trivial part of overall national policy on hospitals. (For example, I have never seen mental hospitals mentioned in discussions of the "hot" topic of hospital cost-containment.)

The national data on these issues are difficult to come by. One must often piece together a puzzle with bits of information from various sources. No single agency or source tracks data broadly enough to address any of these questions completely. This article describes recent research by myself and others to assess the scientific information on these five assertions. We have accumulated what is available relevant to these questions, including rather significant but previously unpublished data.

This article focuses on the following questions:

1. Is mental hospitalization efficacious and cost-effective?
2. How many people are hospitalized for mental disorders? What is the rate of hospitalization (per 100,000 population)?
3. How long do they stay?
4. Has the rate of rehospitalization been rising?
5. What proportion of total hospital days are for mental disorders?

## *Definitional Issues*

In discussions of mental hospitalization, confusion often results from inadequate understanding of the terms used. For example, it has frequently been asserted that the number of residents in public mental hospitals has decreased drastically in the last 20 years or so. This sounds like a rather general statement, but in fact it is very specific and defines a limited set of circumstances.

The phrase *public mental hospitals* refers to state and county mental hospitals, not all hospitals where mental patients are treated. Patients are also treated in such places as VA hospitals (both psychiatric and general), private mental hospitals, community mental health centers, public and private general hospitals with and without separate psychiatric units, and residential treatment centers. Consequently, when one refers to public mental hospitals, the statement is limited to one specific site where people are hospitalized for mental disorders.

The term *residents* refers to the number of people in a hospital at a given time (January 1 in the NIMH data). It does not indicate the number of people hospitalized within a year. *Episode* refers to the total clinical occurrence of a mental disorder. An inpatient episode begins when a patient is hospitalized and ends when the patient is discharged. In national epidemiological data, episodes typically refers to resident patients at the beginning of a reporting year plus all admissions during the year.[1] Since an individual may account for more than one episode during the year (by being discharged and subsequently readmitted), many national data include some duplication of people.

## *Sources of Data*

There is no one national source of data reporting on episodes or people hospitalized for mental disorders. NIMH is the most frequently cited source. However, other important reporting sources include the American Hospital Association (AHA), the National Center for Health Statistics (NCHS), the National Association of Private Psychiatric Hospitals (NAPPH), and the Veterans Administration (VA). Each of these organizations does some survey work of services for mental health care. There is considerable variation across organizations, years, and particular surveys in the breadth of the coverage by the survey regarding sampling proportions, categories of patients and institutions covered, and the like (cf. Sibulkin & Kiesler, in press, for the methodological details on all such surveys and data bases that were found). Consequently, considerable care must be taken in looking at the details of any particular survey in any year.

In all the data to follow, I have tried to make a methodological judgment about the reliability and validity of alternative sources of data. In all cases, I indicate where the data were obtained and the latest year that they cover. Readers interested in the specific details of these judgments, year by year data totals, and the total reference list are referred to the specific articles referenced here.

## *Does Mental Hospitalization Work?*

The effects of mental hospitalization have been reasonably controversial for the 150 years that such hospitalization has been a professional practice. The current approach to mental hospitalization is believed to have begun with the "moral treatment" devised by Pinel in the first half of the 19th century in Europe (cf. Grob, 1973; Mechanic, 1980). There were several successful implementations of this concept in the United States, but the person who had the greatest influence on the development of mental hospitalization here was Dorothea Dix. Dix attempted to extrapolate the concept of moral treatment to apply it to the poor, who were often incarcerated in jails, alms houses, or driven from town to town. Dix's organizational ability was quite incredible; she is given personal credit for the establishment of state mental hospitals in 34 separate states in the United States. The idea behind this method of treatment was to take the mentally disturbed out of the confusing and conflicting press of ordinary life and to remove them to a calm and loving environment far from the hectic urban life (which accounts for the isolated placement of many state mental hospitals). It is interesting to note that in the original implementation of this concept, mental health practitioners were not involved in treatment. It was only later that physicians became involved, and they typically became the superintendents of such institutions. The pristine concept of moral treatment did not remain intact for very long. State mental institutions soon deteriorated into the sorts of snake pits described by Clifford Beers (1908) in his famous book. The historian Grob (1973) and the medical sociologist Mechanic (1980) both feel that much of the deterioration of quality of treatment in mental institutions was caused by their very rapid increase in size. The increased number of patients forced the institutions to adopt a more distant and bureaucratic approach to them to maintain the organization of the institution and administer it smoothly.

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[1] Epidemiologists typically refer to this statistic as "period prevalence," consisting of the point prevalence at the beginning of a specified period plus all new cases that occur during the period (cf. Palinkas & Hoiberg, 1982).

The change in treatment within mental institutions has not been consistent over the years, however. The original Joint Commission on Mental Illness and Mental Health (Joint Commission on Mental Illness and Health, 1961) reports several glowing evaluations of the effects of mental institutionalization during the latter part of the 19th century. One report in particular reported a cure rate of over 70% for the people placed in institutions, as ascertained during a follow-up five years after original discharge. The validity and reliability of these data cannot be ascertained in detail, but it does represent an astonishingly modern form of evaluation research a century ago.

Modern mental institutions have always had serious and articulate critics (e.g., Goffman, 1961). Nonetheless, there have been surprisingly few attempts to evaluate the effects of mental hospital treatment using rigorous scientific criteria. As Kiesler (1982) points out, there are several criteria to satisfy minimal scientific methodological constraints. The most critical of these is random assignment to condition. Demographic and other variables that contribute to someone's being mentally hospitalized, the complexity of the treatment itself, qualitative differences between treatment in hospitals and out, and the potential differences in the personalities and problems of the patients involved all undercut methodological comparisons between hospitalized patients and others unless there has been random assignment of patients to a mental hospital or to some alternative mode of care. In addition, a variety of other statistical and methodological requirements must be satisfied before a reasonable comparison can be made. Obviously, reliable and systematic psychiatric evaluations of all patients are important. Further, a reasonably long period of evaluation would be necessary so that the longer term consequences of treatment could be observed. Behavioral and socially valued variables such as employment, salary, ability to live independently, demonstrations of the capacity to maintain close personal relationships, and the like would also be valuable to measure.

In searching the literature, I was able to find 10 studies involving seriously disturbed patients in which there had been random assignment of patients to a mental hospital or to some alternative mode of care (see Kiesler, 1982). All patients were sufficiently disturbed so as to be initially recommended for hospitalization. The studies varied a great deal regarding the specific alternative care offered, although methods of treatment emphasizing social systems and competency training were disproportionately represented across the 10 experiments. The studies also varied in the degree of methodological detail, the measurement of such important aspects as amount and type of medication, and the length of follow-up. Further, the purpose of almost every study was to test out someone's pet theory of alternative care. As a result, several studies are well-known under the general rubric of alternative care, without scientists closely attending to the important and rare element of random assignment to condition.

Essentially, my secondary analysis reversed the original methodological intent of the 10 studies. I considered the hospitalized patients (the H group) to be the experimental condition, and the alternative care conditions (the AC group) to be a very heterogeneous set of comparison conditions. This form of secondary analysis can be a powerful technique. To the degree that the data are consistent across the studies, one cannot attribute outcomes to variables that vary among the studies. For example, in several cases patients were excluded prior to random assignment on the grounds that they were either too disturbed or too well. The proportion of patients thus excluded varied from 78% to 0%. An alternative explanation for results that depends on a hypothesis that the patients were not seriously disturbed is applicable to some studies but not others. Since it does not apply to all studies, it cannot be posed as a general explanation across the studies. More generally, any methodological or statistical detail in a given study cannot be posed as a general explanation for the total group of studies if the studies vary in the detail but not the outcome.

Across the 10 studies, the effects of alternative care were consistently more positive than those of mental hospitalization. In addition, there was clear evidence of the self-perpetuation of mental hospitalization. Across the studies which included that statistic, people who were randomly assigned to a mental hospital were more likely, after discharge, to be readmitted to the hospital than people who were randomly assigned to an alternative mode of care were ever to be admitted to mental hospitals.

The differences in outcome effectiveness are very consistent across the 10 studies. Although the differences between conditions lessened with time, some effects were still observed several years later. Moreover, the alternative modes of care were less expensive than mental hospitalization. In each of the 10 original reports the alternative mode of care was less expensive. I note, however, that subsequent economic analysis of one of the studies (Weisbrod, Test, & Stein, 1980) appears to contradict this generalization, and the economic analyses in general varied in their sophistication. The most sophisticated economic analysis favored the alternative care by a cost differential of 40%.

My literature review was limited to studies of alternatives to full hospitalization (including day hospitalization), with a methodological requirement of random assignment to condition. Since that article went to press I have become aware of three other overlapping but independent efforts to review some or all of this literature. Braun, Kochansky, Shapiro, Greenberg, Gudeman, Johnson, and Shore (1981) reviewed this literature plus alternatives to continued hospitalization. They did not limit themselves to studies with random assignment, but concluded, "experimental alternatives to hospital care of patients have led to psychiatric outcomes not different from and occasionally superior to those of patients in control groups. The conclusion is best supported for alternatives to admission and for modification to conventional hospitalization" (p. 736). Six of the studies they reviewed involved random assignment to condition. Greene and De La Cruz (1981) reviewed 11 studies of day treatment, four with random assignment. They concluded that day treatment is superior in facilitating social adjustment and "on a par with full-time hospitalization regarding its effectiveness in alleviating psychopathological symptoms, in reducing family stress, and in preventing subsequent hospitalization" (p. 199). It is interesting to note that Greene and De La Cruz included evaluative ratings of methodological rigor (Parloff & Dies, 1978). The ratings of the four true experiments ranged from B+ to D, (on an A–F scale).

Straw (1982) has compiled the most thorough review in a meta-analysis of alternatives to mental hospitalization. He analyzed the data from 30 studies, 16 of which I would judge as involving random assignment (9 overlap with my review). Straw did not analyze the studies with random assignment separately, but concluded that "most, if not all, patients can be treated in the community" (p. 155) but cautioned that it is difficult to conclude that AC groups are superior on any specific outcome.

These four rather different approaches to reviewing a similar and overlapping literature yield very similar conclusions. Alternative care always is as good or better than hospitalization regarding outcomes, and almost always is less expensive. The uniformity of general results across studies is quite striking given substantial variations in methodological rigor, the power of the tests, and the variations in actual treatment alternatives.

However, to say that these studies satisfy the basic conditions for a true experiment does not mean they are without methodological problems. There are a number of such problems related to details not reported (e.g., drug dosages), posttest measures taken by people not blind to experimental condition, a shotgun approach to dependent measures,[2] potential Hawthorne effects, and contaminated mediating processes. Any given study can possibly be critiqued or even explained by one or the other of these problems. However, none of the problems runs throughout the studies, and hence none provides an alternative explanation for all the studies. They do deserve further investigation and discussion.

One important contaminant is the Hawthorne effect, in which the interest and enthusiasm generated by a new technique determines its effectiveness rather than the technique itself. Straw and I tend to have somewhat different ideas on the potential of the Hawthorne effect to explain these data. My sense of it is more or less the following. The authors of several studies reported considerable resistance and antagonism of the staff to the study, not enthusiasm. One study was serendipitous, resulting from an unanticipated closing of a mental health unit, without any staff enthusiasm for that situation. In another, all treatment occurred in group therapy sessions with hospitalized and alternative care patients mixed together. The Hawthorne effect is so clearly ruled out in a sufficient number of studies as to be rendered very unlikely as an overall alternative explanation for the group of studies. Straw (1982), on the other hand, included a measure in his meta-analysis of the authors' "allegiance to the innovation." Greater allegiance correlated with a larger effect size.

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[2] The fairly arbitrary inclusion of large sets of dependent variables creates potential problems for meta-analysis. Not all could be expected to show significant effects, but all are included in the meta-analysis. In Straw's (1982) case, if the specific number (mean, variance) of an effect were not reported, he counted the effect size as zero, probably making his overall analysis of effect size quite conservative.

However, the allegiance measure was based upon the coders' rating of the enthusiasm the authors expressed for this innovation in the publication. This could indeed be the Hawthorne effect at work. It could also be that authors with more powerful effects write more enthusiastically about them.

It also is not entirely clear whether reduced admission to hospitals by the AC groups is due specifically to the innovative technique, the "debilitating" experience in the hospital, or the outcome of general medical practices. For example, Silverman and Saunders (1980) found that 41% of the variance in admission rates (between counties in Ontario) was explained by physical proximity to the hospital. Different types of practitioners also differed systematically in their propensity to hospitalize any specific patient (cf. Straw, 1982). One must remember that all patients in these studies were originally recommended to be hospitalized. If the hospitalized patients have further difficulties after discharge, returning to the original professionals (who have already displayed a willingness to hospitalize them) may be the key variable rather than the state of the patients. The reduced proportion of hospitalization for AC patients may simply reflect their disinclination to return to the attending professional who originally recommended them for inpatient care.

Such ambiguities deserve further investigation. Particularly, the comparative power of types of alternative care needs to be investigated. The consistency of these results, however, is still notable. In spite of some methodological problems and continuing ambiguities, every comparative test has shown alternative care to be as good as or better than hospitalization.

## *How Many People Are Hospitalized for Mental Disorders?*

Stated in this form, this question cannot be answered at a national level. The only national data gathered from any source are the numbers of clinical episodes of inpatient hospitalization, not the numbers of people. Some duplication of people results from the counting of episodes, and I will review this evidence later. However, the only national evidence available refers to clinical episodes of inpatient care, and it is this question which this section addresses.

Kiesler and Sibulkin (in press-a) thoroughly reviewed several different sources of national data regarding inpatient episodes. They investigated inpatient episodes in state and county mental hospitals, in the VA system, in private mental hospitals, in general hospitals both with and without psychiatric units, in CMHCs, and in residential treatment centers. Data on episodes per se were not available in every case and sometimes had to be approximated through other means. No national source reviewed all of the data on all of these sites of hospitalization, and we therefore attempted to distinguish among sources regarding the coverage of the data provided. In addition, there is some difference among sources in the latest year of data provided.

Table 1 shows the aggregated estimates that Kiesler and Sibulkin derived from these various sources. There are several things to be noted from that table. First, we were able to uncover approximately 3 million clinical episodes of inpatient care. This contrasts with the often-quoted official estimate of 1.7 million, based on NIMH estimates alone. The data also do not include the approximately one million cases for which mental disorder was a secondary diagnosis. Further, these data do not include estimates of clinical episodes in nursing homes where the primary disorder is mental. If one included mental disorders treated within the context of nursing homes, then the total would be closer to 3.8 million. Our method, which we refer to as a multiple-source method of estimation, surely is more reliable than any other method of counting episodes currently available. We derive more reliable estimates by looking across sites and closely inspecting alternative data batches. Table 1 reports only the most recent data that we were able to obtain on mental hospitalization. The reader is referred to the original article for the data over years for each of the sources listed and each of the hospital sites listed in Table 1.

The site of mental hospitalization has changed dramatically in recent years. More inpatient episodes (almost 60% of the total) occur in general hospitals than in any other setting. The changing site has another interesting implication. If one would ask the lay public (perhaps even professionals) to discuss mental hospitalization, they would probably concentrate on the stereotype of private mental hospitals and state/county mental hospitals. This stereotype of where people are hospitalized for mental disorders is startlingly out of date. Private mental hospitals and state/county mental hospitals together now account for only about 25% of the total number of episodes of mental hospitalization.

TABLE 1

*Aggregated Estimates of Number of Inpatient Psychiatric Episodes in the United States*

| Site | Estimated episodes | Unit of analysis | Source | Latest year |
|---|---|---|---|---|
| State/county hospital | 574,000 | Episodes | NIMH | 1977 |
| VA hospital | 209,000 | Episodes[a] | VA | 1980 |
| Private mental hospital | 151,000 | Episodes | NIMH | 1977 |
| General hospital | 1,746,000 | Discharges + ADC[b] | NCHS | 1980 |
| CMHCs | 299,000 | Episodes | NIMH | 1978 |
| Resident treatment center | 33,500 | Episodes | NIMH | 1977 |
| Total | 3,012,500[c] | | | |

*Note*. From "People, Clinical Episodes, and Mental Hospitalization: A Multiple-Source Method of Estimation" by C. A. Kiesler and A. E. Sibulkin, in R. F. Kidd and M. J. Saks (Eds.), *Advances in Applied Social Psychology*. Copyright 1982 by Lawrence Erlbaum Associates. Reprinted by permission. NIMH = National Institute of Mental Health, VA = Veterans Administration, NCHS = National Center for Health Statistics, CMHC = community mental health center, ADC = average daily census.

[a] Authors' calculation.

[b] The ADC could only be estimated here. An ADC of 54,000 was derived by dividing the 19,578,000 total days of care (including any in the previous year) accumulated by the discharges during the year by 365. A true average daily census is calculated by dividing inpatient days by 365.

[c] Does not include nursing homes or secondary diagnoses of mental disorder.

## *The Rate of Mental Hospitalization*

The previous section presents the most recent estimate of the total number of episodes of mental hospitalization in the various sites. This section will discuss the rate of mental hospitalization (per 100,000 population). Experts in the field have generally accepted that the rate of hospitalization has been stable over the last 15 years or so (Klerman, 1979; Pardes, 1981). However, whether the rate is stable depends on how one views the episodes occurring in general hospitals, specifically those without formal psychiatric units.

NIMH views its mission as being to concentrate on the "specialty mental health sector." In that context, the institute periodically surveys episodes occurring in general hospitals with psychiatric units. In the most recent survey in 1977, NIMH estimated that 574,000 inpatient episodes for mental disorders occurred in general hospitals with psychiatric units. On the other hand, in 1979 NCHS constructed a sample of episodes in all general hospitals, with or without psychiatric units. Their total was 1,775,000 episodes for mental disorders. The NCHS estimate represents the total; the NIMH one represents the subset of hospitals with psychiatric units. If simple subtraction would suffice,[3] this would mean that approximately 1.2 million inpatient episodes are occurring in general hospitals without psychiatric units. This represents about 40% of the total episodes in the United States and makes general hospitals without psychiatric units the most popular site for mental hospitalization.

Quite different conclusions are reached regarding total inpatient episodes, depending on whether one focuses only on the "specialty mental health sector" or looks at all general hospitals. Indeed, most of the difference between our estimates of total episodes and those of NIMH can be attributed to our inclusion of all general hospitals in our data base. The methodological difference obviously affects the total, but the stability of the rate of hospitalization over years would not necessarily be affected.

Kiesler and Sibulkin (Note 1) calculated the rate of hospitalization by each method over a 15-year period for which data were available (1965–1979). The results are presented in Figure 1. As Figure 1 shows, excluding general hospitals without psychiatric units produces a stable rate of hospitalization across years (the slope of the best fit line is near zero).

Including all general hospital episodes leads to a rate of hospitalization increasing across years in an approximately linear fashion (slope = 34.8, $t = 13.4$, $p < .001$). One can see why the difference in slopes is so sharp by looking only at episodes in general hospitals without psychiatric units. Kiesler and Sibulkin estimated that in 1965 there were only 184,000 such episodes; this figure rose steadily over the years to 1,200,000 in 1979.

If one includes all cases, the rate of mental hospitalization is increasing linearly. However, the

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[3] There are several problems with the subtraction method. First, each total is an estimate based on a sample survey. The reliability of the difference is less than that of either alone. Second, there is potentially some duplicate reporting between the NCHS estimate and the CMHCs that are affiliated with a general hospital without a psychiatric unit. The maximum potential duplication is not sufficient to disturb the conclusions reached in this section, but it does make the subtraction method less reliable.

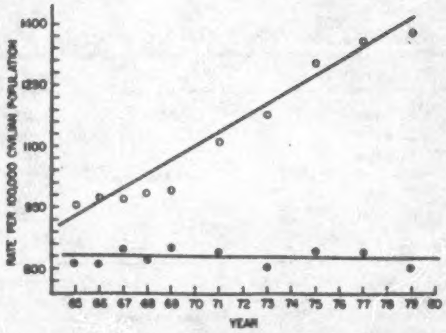

Figure 1. Number of inpatient episodes for mental disorders per 100,000 civilian population, 1965–1979. (Solid line represents best fit line. Black dots represent NIMH data and exclude inpatient episodes occurring in general hospitals without psychiatric units. Open circles are from Kiesler & Sibulkin [Note 1] and represent all inpatient episodes, including those in general hospitals without psychiatric units.)

conclusion of increase in rate or stability depends on how one views episodes in general hospitals without psychiatric units. Suppose, as some have privately suggested to me, those episodes occur only for diagnosis and referral, not active treatment. If so, then there should be no difference in such factors as age, sex, and diagnosis of patients in hospitals with and without psychiatric units (since the latter are to be transferred later, according to this hypothesis), but the stay of the latter should be extremely short. Direct investigation of these issues is not yet possible, but Kiesler and Sibulkin (Note 1) applied their crude subtraction method to the data at hand. Compared to psychiatric units, patients in other general hospitals disproportionately tended to be over 35, male, and alcoholic or neurotic (all $ps < .001$). The average length of stay was approximately eight days. Eight days is considered a short stay for psychiatric disorders, but it is still within that considered appropriate for brief treatment (e.g., Glick & Hargreaves, 1979), and it is approximately equal to the average hospital stay for all medical disorders.

Clearly more direct investigation of psychiatric patients in general hospitals without psychiatric units is needed. However, the preliminary evidence suggests that they are not there simply for diagnosis and referral and that some sort of active, although brief, treatment program is being carried out. If so, one must include such cases in the national data base and thereby conclude an increasing rate of mental hospitalization.

## *How Long Do People Stay in Mental Hospitals?*

Conceptually, the notion of a length of stay for mental disorder in a hospital is simple. One simply notes when the patient arrived and was discharged, and merely calculates the elapsed time. In practice, however, lengths of stay in hospitals for mental disorders are only rarely noted. Most national statistics published in the area of mental health do not reflect true lengths of stay.

In national statistics, hospitals do routinely keep track of such statistics as admissions, discharges, residents, average daily census (ADC; the average number of patients per day during the year), episodes (residents plus admissions), and the total number of inpatient days (ADC × 365).

These statistics are often used to calculate length of stay at a national level, but the resulting statistics are incorrect and can be substantially misleading. Typically, the total number of inpatient days during the year is divided by either admissions or discharges. In the numerator of such a ratio only the days spent by patients during that year are calculated. Any days spent by patients prior to the beginning of the reporting period but who continue on in the hospital are not noted, and any days spent beyond the yearly reporting period by patients who continue in the hospital at the end of the year are also not noted.

How inaccurate an aggregated length of stay (LOS) can be depends on several factors. If the number of days spent by the aggregated patients prior to the beginning of the reporting period equals the number of days spent by patients after the reporting period, the ratio is more accurate. The ratio gains accuracy to the extent that the number of admissions equals the number of discharges. Of course, if any patients are in the hospital throughout the reporting period (i.e., they spend more than one year in the hospital), the statistics will be seriously inaccurate. Phrased a different way, if the true length of stay is decreasing (as some people say it is), then any of the aggregate statistics will lead to an underestimate of the true length of stay. Total inpatient days, which is a routine national statistic, cannot be used to calculate a true length of stay. The correct statistic is called *discharge days* or *days of care*. Discharge days cannot be derived from aggregate national statistics and must be calculated from individual medical records.

Although Kiesler and Sibulkin (in press-b) perused all of the same sources of data used in the study calculating the number of clinical inpatient episodes, the discharge days were only rarely available. NIMH, for example, does not include discharge days on its most frequent surveys and only includes them for community mental health centers since 1980. We were able to find a few NIMH sample surveys of patient records that reported median length of stay. The American Hospital Association survey does include an item on discharge days for its hospitals, but it does not publish the results. Our major source was the National Center for Health Statistics. Statistics for true length of stay had been published for two different years, and we were able to obtain previously unpublished data for seven additional years from the NCHS National Master Facility Inventory. However, those data cannot be applied to general hospitals since the hospital (rather than the discharge record) is the unit of analysis in those AHA–NCHS surveys. For general hospitals, we were able to obtain some data from a different NCHS survey, the National Hospital Discharge Survey (NHDS). The AMIS VA data system does not include discharge days, but a separate information system, the patient treatment file (PTF), does. In the data to follow, therefore, the VA patient treatment file was used for their hospitals, the NCHS Master Facility Inventory was used for state/county and private mental hospitals, and the NCHS National Hospital Discharge Survey provided data for general hospitals. NIMH provides the only data for CMHCs, and these do not include true length of stay, but we were able to estimate at least the direction of the error in those statistics.

Table 2 represents the summary of trends in the length of hospital stay for mental disorders over the last decade or so (see Kiesler & Sibulkin, in press-b). As one can see, only rarely were both the mean and median number of days available. This is important since the distributions of lengths of stay are highly skewed toward longer length of stay. There are several things to note from these data. First, the average length of stay varies greatly across hospital sites, from 11.6 days in general hospitals to six months for state/county hospitals. Second, only two of the seven sites (VA psychiatric hospitals and state/county hospitals) have experienced a decrease in LOS in the last decade or so. All other sites of hospitalization, which account for almost 80% of the inpatient episodes, have had stable LOS during that time period.

TABLE 2

*Summary of Trends in Length of Hospital Stay for Mental Disorders by Site*

| Site | Trend of LOS during 1970s | Latest figures | | Year of latest LOS |
|---|---|---|---|---|
| | | *M* | *Mdn* | |
| VA general hospital | | | | |
| Psychotic | Stable | 74.1 | | 1978 |
| Nonpsychotic | Stable | 28.0 | | 1978 |
| VA psychiatric hospital | | | | |
| Psychotic | Very sharp decrease | 160.6 | | 1978 |
| Nonpsychotic | Slight decrease | 52.9 | | 1978 |
| General hospital[a] | Stable | 11.6 | 6.9 | 1980 |
| State/county hospital | Very sharp decrease | 189.1 | 25.5[b] | 1978 |
| Private (profit) | Stable | 31.6 | 20.2[b] | 1978 |
| Private (nonprofit) | Fluctuating | 42.3 | | 1978 |
| CHMCs | Stable | 13.6[c] | NA | 1978 |

*Note*. From "Episodic Length of Hospital Stay for Mental Disorders" by C. A. Kiesler and A. E. Sibulkin, in C. M. Stephenson and J. H. Davis (Eds.), *Progress in Applied Social Psychology*. Copyright 1982 by John Wiley & Sons. Reprinted by permission. VA = Veterans Administration, CMHC = community mental health center, LOS = length of stay.

[a] Includes hospitals with and without psychiatric units.

[b] From the National Institute of Mental Health's 1975 survey of admissions (Mental Health National Statistics Series CN No. 2).

[c] Approximate, see text.

The average length of stay for both state/county hospitals and the VA psychiatric hospitals has been dropping for years. For example, in 1954 the average length of stay for psychotics in all VA hospitals was 445 days (a median of 66 days); it peaked at 672 days in 1958, and it has continued to fall fairly systematically (sharply in the last 15 years) to a mean of 92 days (a median of 22 days) in 1980. We have only 9 years of true length of stay statistics for state/county mental hospitals, based on the NCHS surveys from 1969 to 1978. The average length of stay in state and county mental hospitals in 1969 was 421 days, falling consistently and sharply to 189 days in 1978. By contrast, nonfederal short stay (i.e., general) hospitals, which handle a majority of national inpatient episodes now, have remained very stable, with an average length of stay of 12.6 days in 1965 and 11.6 in 1980.

One has to qualify the answer to the question, How long do people stay in mental hospitals?, by the site in which one is hospitalized. Among possible sites, there is a 16:1 ratio between the shortest average length of stay and the longest. Further, even though the average length of stay, irrespective of site, has decreased, the total decrease is completely due to sharp decreases in the two sites that began with and still have the longest average lengths of stay. The shorter lengths of stay seem to have stabilized in most hospital sites.

## *Has the Rate of Rehospitalization Been Rising?*

The question of the rate of rehospitalization is a very complex one. There are two basic approaches, neither of which is feasible given the current array of national record-keeping. One method is to follow individual inpatients across the rest of their lives to see how many times they have been rehospitalized. The modified form of this approach is to look at the rehospitalization rate within a reasonably lengthy but still specified length of time, such as 10 years. No such data exist at the national level, and despite considerable national discussion, the question cannot be answered either precisely or directly.

This question also has implications for the data already presented. The two previous sections describing hospitalization rate and length of hospital stay refer in both cases to episodes, not to people. Within any given year, it would be of interest to ascertain how many people were actually involved, which demands that we know how many episodes each person accounts for on the average. There are some data on this issue.

The data that have been discussed most frequently over the years derive from a study by Bahn, Gorwitz, Klee, Kramer, and Tuerk (1965) on the first-year data for the Maryland State Psychiatric Register. Such registers attempt to track all psychiatric episodes, whether inpatient or outpatient, within a given year. They typically underestimate the number of outpatient episodes and visits because the state or county registers tend to track only the practices of psychiatrists and exclude other mental health professionals, such as social workers and psychologists. On the other hand, one would expect such estimates to be substantially more accurate for inpatient episodes. Bahn et al. found each hospitalized patient to account for 1.2 inpatient episodes during that year. Thus one could multiply the reciprocal of that number (.83) by the number of episodes to derive the actual number of people involved. It is important to note that their study was for one year only, did not track people beyond that time period, was derived almost 20 years ago, and covered only one specific geographical region of the United States.

More recently Goldberg and Allen (Note 2) completed a multiple-year study of the Monroe County (New York) Psychiatric Case Register. Some of the comparisons lack reliability because of changes in record-keeping over the years. However, they were able to study one five-year period intensively. Goldberg and Allen found an average of 1.35 episodes per person during each year, leading to a correction factor of approximately .74. This is a slightly higher readmission rate than the Maryland data of 15 years earlier.

The alleged "revolving door" phenomenon demands such a difference in readmission rates. However, it is difficult to tell whether the difference between these two studies reflects changed national treatment practice or rather some other alternative mechanism based on differences between the two regions or the difference in time. I do want to note several things. The readmission rate found by Goldberg and Allen is only about 12% higher for the mid-1970s than Bahn et al. found for the early 1960s. Consequently, this slight change in the readmission rate could in no way be used to explain the much more dramatic increase in number of total inpatient episodes nationally. There is another problem in attempting to use these data to support a revolving door hypothesis. Even though the average readmission rate found by Goldberg and Allen was 12% greater than that found by Bahn et al., Goldberg and Allen found no difference in readmission rate across the five-year period they studied very intensively. If one wishes to infer that the difference in readmission rate between these two studies is real, then one must also conclude that the readmission rate is no longer rising.

Looked at a different way, a slight increase in readmission rate would not necessarily be cause for alarm. During the time period covered by these two studies, the average length of stay at hospitals decreased substantially more than the difference in readmission rates found in the two studies. Assuming the difference in readmission rate to be reliable, valid, and reflective of the nation at large, the inference would be that we put people in mental hospitals slightly more often but for much less time each episode, making for a substantially decreased total number of inpatient days per person.

The Bahn et al. study was for one year only. The Goldberg and Allen study, even though reflecting multiple years, deals with data that are within-year only. We have no way of ascertaining whether people hospitalized in Year 1 were also hospitalized in Years 2, 3, and 4. The data were not gathered in a way that allows such an analysis. There is some evidence that one should track individuals across years rather than simply within years. An NIMH study over a 10-year period with Monroe County data clearly demonstrates this point (NIMH, 1976). NIMH reported the number of psychiatric inpatient days spent in the first year in which a patient was admitted, and a total for the 10-year period. (They did not break the data down year by year.) In that study, patients spent an average of 86 inpatient days in the first year they were hospitalized. The same patients spent an average of 332 inpatient days over the course of the 10-year period. Only about a fourth of the total inpatient days in the 10-year period occurred during the first year following admission. This finding suggests very strongly that we should be tracking patients over years; we cannot easily evaluate the outcomes of our national inpatient policy without such data.

With the same constraint in mind, it is still possible that the national readmission rate for inpatient care has risen much more dramatically than the difference between the Bahn et al. and Goldberg and Allen studies indicates. We may still have a revolving door phenomenon, but simply now have a longer period of time between a given discharge from a hospital and the next readmission. An increase in readmission rates might be detected if one were to go beyond the one-year data period.

There are other data on readmission rates restricted to specific sites. For example, it seems very clear that the proportion of patients who are hospitalized in state and county mental hospitals who have been hospitalized before has increased fairly substantially (NIMH, 1976). However, there are several conceptual problems in using such data to infer a more general increase in readmission rates. First, the state and county mental hospital is only one of a number of possible places in which to hospitalize people with mental disorders. Second, it is a site that accounts for a rapidly decreasing percentage of the total number of national episodes. Third, because the number of episodes and the proportion of the total has been decreasing, the diagnostic categories may have been changing as well. The total national aggregate of inpatient episodes (rather than only one site) needs to be taken into account. Fourth, state and county mental hospitals are the places that traditionally have had the longest length of stay, and they have gone through a recent dumping-out of patients who have been in the hospital for a long period of time (many for more than 10 years). Long periods of time spent in a state/county mental hospital undercut one's ability to deal independently with life outside. The data previously presented on alternative modes of care were accumulated in sites substantially more professionally advanced than state/county mental hospitals, with substantially shorter average lengths of stay. Even there one apparently finds evidence of mental hospitalization undercutting one's competence to live independently outside the institution. One can only infer that a long stay at a state or county mental hospital would exaggerate this phenomenon. In short, the increase in proportion of state/county patients who have been in mental hospitals before could well be due to the specific types of patients and their previous institutional experience.

In summary, the data on the revolving door phenomenon are surprisingly sparse. No national data allow one to make such an inference. The best data existing are those accumulated by Goldberg and Allen (Note 2). However, they reflect one county only and are stable over an intensively studied five-year period. Goldberg and Allen do find higher readmission rates for the mid-1970s than Bahn et al. (1965) found for the early 1960s. However, other differences between the two places where the data were gathered could easily account for the difference. Many of our professional colleagues are firmly convinced that a revolving door phenomenon exists. We do not have the data to rule out the possibility, but there are no impeccable data with clear support for it.[4]

### *What Proportion of Total Hospital Days Are for Mental Disorders?*

As mentioned previously, the National Center for Health Statistics has published two years of data on its Master Facility Inventory (actually based on AHA data). These data are the best source of data on true length of stay, but they also include an exceptionally useful statistic. NCHS listed the total hospital days spent in the United States for particular disorders. Kiesler and Sibulkin (Note 3)

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[4] The study of readmissions for mental disorders should be placed in the more general context of readmissions for other disorders. Zook and Moore (1980) have found that 13% of general hospital patients use over half of the hospital resources in a year. Zook, Savickis, and Moore (1980) found for mental disorders that 61.5% of the hospitalized patients had been there before. This figure was less than that for such diagnoses as spinal cord injury (95.3%), alcohol-related gastrointestinal disease (80%), benign lung disease (71%), and endocrine/metabolic disorder (62.2%), but more than that for benign bowel disease (50.2%).

TABLE 3

*Number of Inpatient Days in Various Sites According to NCHS, VA, and NIMH Surveys, 1969–1978*

| Site | 1978 | 1977 | 1976 | 1975 | 1974 | 1973 | 1972 | 1971 | 1969 |
|---|---|---|---|---|---|---|---|---|---|
| VA psychiatric sections | | | | | | | | | |
| 1. General hospital | 5.247 | 5.207 | 5.277 | 5.166 | 4.650 | 4.536 | 4.504 | 3.731 | 2.726 |
| 2. Psychiatric hospital | 3.088 | 3.364 | 3.780 | 4.345 | 5.145 | 5.697 | 6.966 | 10.021 | 13.283 |
| 3. State mental hospital | 51.458 | 56.582 | 61.217 | 69.119 | 77.868 | 89.246 | 100.604 | 113.821 | 131.555 |
| Private mental hospitals | | | | | | | | | |
| 4. Profit | 2.630 | 2.474 | 2.380 | 2.343 | 2.216 | 2.174 | 1.786 | 1.991 | 1.987 |
| 5. Nonprofit | 2.816 | 2.482 | 2.453 | 2.457 | 2.357 | 2.137 | 2.251 | 2.486 | 3.272 |
| 6. General hospital[a,b] | 19.435 | 17.606 | 15.604 | 16.496 | 15.248 | 14.176 | 13.666 | 12.341 | 9.760[c] |
| 7. CMHCs | 4.063 | 3.818 | 3.951 | 3.948 | 3.836 | 3.276 | 2.562 | 2.225 | 1.129[d] |
| 8. RTCs | 6.433[f] | 6.433 | 5.900[f] | 5.900 | 6.338[f] | 6.338 | 4.521[f] | 4.521[f] | 4.521 |
| 9. Total psychiatric days | 95.170 | 97.966 | 100.607 | 109.774 | 117.658 | 127.580 | 136.860 | 151.139 | 168.233 |
| 10. Total NCHS inpatient days | 370.930 | 376.792 | 384.461 | 391.437 | 400.070 | 408.858 | 416.066 | 434.290 | 462.360[c] |
| 11. Total NCHS inpatient days & CMHCs & RTCs | 381.426 | 387.043 | 394.312 | 401.285 | 410.244 | 418.472 | 423.140 | 441.036 | 467.950 |
| 12. % all days | 25% | 25% | 26% | 27% | 29% | 30% | 32% | 34% | 36% |

*Note.* Table entries are given in millions. VA = Veterans Administration, CMHC = community mental health center, RTC = residential treatment center, NIMH = National Institute of Mental Health, NCHS = National Center for Health Statistics.

[a] The National Hospital Discharge Survey universe includes discharges from all nonfederal short-stay hospitals, not just general ones (see text).

[b] These are discharge days, not inpatient days (see text).

[c] Discharge days in 1968, medical data for 1969 are not available.

[d] Data concerning inpatient days for 1969 are not available. This figure was estimated by multiplying the 1,923,720 inpatient days in 1970 by .59 (the same ratio the 1969 episodes are to the 1970 episodes).

[e] Approximated by multiplying the number of patients present on the last day of the reporting period by 365.

[f] Previous year's data.

were therefore able to calculate the proportion of total hospital days in the United States that were for mental disorders. NCHS cooperated in furnishing us with previously unpublished data from seven additional years. This section presents the nine years of data that we have on total hospital days and those spent for mental disorders.

The NCHS data must be corrected somewhat; they do not include the hospital days for CMHCs, RTCs, nor those for the VA.[8] Consequently Kiesler and Sibulkin added those totals to the NCHS data for both mental disorders and the total hospital days. Table 3 presents the resulting array that Kiesler and Sibulkin (Note 3) were able to derive for the years 1969 and 1971–1978.

As one can see, in 1969 there were a total of 468 million hospital days spent in the United States for all disorders, including mental (Line 11). This number fell sharply to 381 million in 1978. In 1969 168 million of those days (36%) were spent for mental disorders (Lines 9 & 12). This number fell to 95 million in 1978, when mental disorders accounted for 25% of the total hospital days spent for all diagnoses. These figures have not been noted elsewhere, and only two years of data have been published. They are quite interesting from several perspectives. Over the decade 1969 to 1978 the total hospital days in the United States fell 18.5%, or over 86.5 million days. Without further inspection, this might be regarded as a resounding success for the improvement of medical practice, surgical techniques, and proponents of hospital cost-containment. On the other hand, 73 million (85%) of those savings are due to the drop in days spent in hospitals for mental disorders.

Mental hospitals have decreased from 168 million inpatient days in 1969 to 95 million in 1978, a decrease of 73 million. In spite of this astonishing decrease, mental disorders still account for 25% of the total hospital days spent in the United States.

The decrease in hospital days for mental disorders has not occurred uniformly across hospitalization sites. Only two sites have decreased since 1969: the VA psychiatric hospitals and the state/county mental hospitals. The state/county mental hospitals have decreased from a total of over 132 million inpatient days in 1969 to 51 million in 1978. Most of this decrease is due to the decrease in the average length of stay in state and county mental hospitals, not to a decrease in episodes. In 1969 the average length of stay in a state hospital was 421 days; by 1978 it had decreased to 189 days.

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[8] The Master Facility Inventory does include "federal psychiatric hospitals," which includes VA hospitals, but only psychiatric ones. Hence, we used data from the VA in order to include general and psychiatric hospitals in our count of psychiatric inpatient days.

During this same decade, the VA (all psychiatric sections) decreased its total number of inpatient days for mental disorders by approximately 50%. This decrease is due mainly to the treatment of psychotics in psychiatric hospitals. The average length of stay for psychotic patients in psychiatric hospitals, 1974 to 1978, fell from 325 days to 161 days. Although psychotics account for a substantial proportion of the decrease in total days in the VA, the LOS for such patients is still lengthy.

These data reveal several startling things. A decade ago, mental disorders accounted for over a third of total inpatient days in the United States (25 years ago, over half; cf. Kiesler & Sibulkin, 1982), and mental disorders still account for a fourth of total inpatient days in the United States. The huge decrease in total medical inpatient days in the United States is almost totally accounted for (85%) by the decrease in inpatient days for mental disorders. The decrease in inpatient days for mental disorders, however, is specific to two hospital sites rather than reflecting general improvement of treatment efficacy.

In spite of the decrease in total days of treatment, we should be careful about assuming similar decreases in costs, even in constant dollars, or about excluding posthospital treatment. The sites surely vary a great deal in per diem costs. Decreases in total days of care have been observed only in sites where per diem costs are less and custodial care more likely (VA psychiatric and state/county hospitals). The largest increase is in one of the most expensive sites, general hospitals. The ultimate cost is surely a joint function of average length of stay, intensity of the treatment, and the specific site.

## *Discussion*

At the beginning of this article I noted that many people believe that we now put fewer people in mental hospitals and for shorter periods of time, but that they are rehospitalized more often. Further, people believe that mental hospitalization is the correct treatment for these few because there is no real alternative treatment available. Finally, mental hospitalization is not seen as a major part of the national structure of hospitalization in general.

All these generalizations are either demonstrably false, are true for only a small part of the national picture, or are essentially uninvestigated. The following represents a more correct set of general statements regarding mental hospitalization.

1. Mental hospitalization is increasing well in excess of the population rate. The validity of this statement depends entirely on one's view of inpatient episodes in general hospitals without psychiatric units. If one excludes them, and preliminary evidence suggests that they should not be excluded, then the rate of mental hospitalization is stable.

2. The site of hospitalization has changed dramatically. The public image of mental hospitalization—the state mental hospital and the private mental hospital—now accounts for only 25% of the total incidence of mental hospitalization.

3. Hospital stays for mental disorders have decreased recently only in state mental hospitals and in VA psychiatric hospitals (which together account for only about 20% of the total episodes) although these still average six and five months, respectively. The other sites of hospitalization have had fairly stable lengths of stay over the last decade or so.

4. At least several more effective alternative treatment modes do exist. Within the limits of minimal scientific methodology, there has been no single unsuccessful effort to discover alternative treatment. Further, mental hospitalization appears to be self-perpetuating, as critics have been suggesting for years.

5. There is little evidence to support or to test the notion of the revolving door phenomenon. The best summary might suggest that (a) rehospitalization rates may be increasing for state mental hospitals; (b) however, a recent 5-year investigation did not show a more general increase across years; (c) the small difference between that time and one 15 years earlier, if valid, would explain only a fraction of the increase of total hospital episodes over the same period. Of all the questions investigated in this article, the issues surrounding the revolving door have the weakest empirical base.

6. Hospitalization for mental disorders accounts for a substantial fraction of the total hospital days in the United States. Approximately 25% of the total hospital days are for mental disorders. Policy alternatives regarding alternative care and decreasing length of stay (particularly in state mental hospitals and psychiatric VA hospitals) could have

significant effects on U.S. hospital cost-containment policy and practices.

Clearly, we must reassess our national policies regarding mental hospitalization. The set of issues raised by these data are so complex that only a few of the more salient aspects can be touched on here.

These kinds of data are very important for the development, evaluation, and progress of public policy on mental health. Data regarding various behavioral and social outcomes of mental hospitalization need to be more accessible to scientists. No agency now tracks all of the variables or all of the hospitalization sites described here. The need for policy-relevant data is enormous (cf. Mechanic, 1978; Rubin, 1980). NIMH is the obvious agency to do this. The supreme irony is that although a substantial increase in budget would be necessary to even begin gathering the appropriate data base, the budget of NIMH's present activities is being severely decreased. A number of existing data-gathering responsibilities have been handed to the states for fiscal reasons. However, to develop an appropriate national data base, it is necessary for the data-gathering approach and the specific items tracked to be either identical or sufficiently similar to be aggregated across states and time. It is unlikely that such outcomes will occur without sufficient direction and financial incentives from the Congress and the executive branch. The new NIMH Mental Health Statistics Improvement Program, designed to encourage uniform reporting by and from states, will help. Nonetheless, it seems likely that the quality of national data regarding mental hospitalization, in spite of the best intentions of involved professionals, will decrease substantially in the next few years.

We need to restructure our approach to mental hospitalization totally. It appears (Kiesler, 1982) that the majority of patients hospitalized for mental disorders could be treated more effectively and less expensively elsewhere. To be more precise, the treatment modalities exist, but specific programs do not (cf. Talbot, 1981). The problems of the deinstitutionalized are legion (e.g., Bachrach, 1976). The data reported here do not suggest that patients can be dumped from institutions. They further do not suggest that a lack of treatment can be considered as a serious alternative to hospitalization. I do not advocate any specific alternative (several seem possible), and more research is clearly needed. However, this is one of those rare circumstances in public policy where the data are sufficiently clear that a variety of actions can be taken without awaiting years of future research. Several treatment modalities appear to be more efficacious and more cost effective than mental hospitalization. Public policy could easily be changed to reflect this fact even while researchers continue to investigate the most promising alternative treatment modalities. Hospitalization for mental disorder is supported by biases in incentives in public and private insurance plans. People are being treated in more costly and less effective environments because it is the only treatment alternative the insurance plan will pay for, or at least pay for completely. A plan that considered the total cost and the patient's welfare might do better to set up financial and professional barriers against hospitalization rather than incentives favoring it.

Prevention has been a difficult concept to sell to federal agencies, to insurance companies, and sometimes to many professionals as well. Certainly these data suggest the development of specific plans and programs to support the prevention of mental hospitalization. Specific approaches might include the revision of professional review organizations and activities, the experimental development of alternative funding mechanisms for treatment of the mentally disturbed, and a substantial investment in research about prevention. One can make a case for the further development of public programs and research on prevention in general (Albee, 1978). The prevention of mental hospitalization and further tests of alternatives to it are one pragmatic subset of such activities.

The review of studies of treatment alternatives discussed in this article includes only studies of treatment used instead of institutionalization. Studies evaluating methods of deinstitutionalizing patients (e.g., Paul & Lentz, 1977) are not included. Space prohibits a detailed review of deinstitutionalization efforts (cf. Bachrach, 1976), but the work of Paul and Lentz is especially noteworthy. They worked with patients who had already been hospitalized for an average of 17 years and who had previously been rejected for community care in spite of aggressive deinstitutionalization efforts. Of the 40 patients in their social learning condition, 36 were ultimately released to room-and-board arrangements, and three others achieved a self-supporting, independent living. The Paul and Lentz technique is meticulous and time-consuming, but clearly very effective.

The work of Paul and Lentz is laudable in its own right as a method to deinstitutionalize patients. However, it is also relevant to this discussion of alternatives to mental hospitalization. That is, the method of treatment requires such control over the patients' environment and such detailed observation of their behavior that it could not be accomplished outside some sort of total environment. The issues surrounding mental hospitalization are very complex. The point is that one should not view mental hospitalization as a homogeneous treatment modality. In the studies I have reviewed, hospitalization did not fare well compared to any one of several treatment alternatives. Research is needed to compare types of treatment modalities (in and out of hospitals) and the ways in which they interact with patient conditions. These are complicated scientific questions, and one should resist overly simplistic and preliminary solutions.

A different information need relates to the activities now taking place in general hospitals without psychiatric units. We know very little about the patients who are being treated in such hospitals, other than that they do not stay long. General hospitals without psychiatric units are now the site where treatment of mental disorders most frequently occurs. NIMH has been tracking some activities in general hospitals with psychiatric units, but very little is known about the hospitals without psychiatric units. The epidemiology, demographics, the payment methods, the treatment modalities utilized, and the outcomes of such treatment all should be investigated thoroughly. It seems strange that we know so little about the hospital site where the most inpatient episodes occur.

These various data deal with primary diagnoses of mental disorder. Secondary diagnoses of mental disorder are even less well tracked. However, the degree to which mental problems are routinely present in physical disorders and vice versa is often incompletely appreciated (cf. Broskowski, Marks, & Budman, 1981). Goplerud (1981) describes a stratified survey in which it was found that 28% of the sample had emotional problems, 39% had one or more physical illnesses, and 26% reported such psychosomatic disorders as nervous stomach, hypertension, and colitis; 10% of the sample reported all three categories, and another 11% reported two of the three (cf. Schwab, Bell, Warheit, & Schwab, 1979). On the other hand, which diagnoses are primary, secondary, or even recognized depends on the perspective and training of the attending physician. Hoeper (1980), for example, found that general practitioners detected only 3% of psychiatric cases when diagnoses were independently assessed.

There is consequently good potential for diagnostic slippage in these data, particularly in sites such as general hospitals without psychiatric units, where psychiatrists and psychologists may be less available for consultation. However, diagnosing a primary mental disorder as physical is more likely than the reverse. The potential for diagnostic error is not bilaterally equiprobable. On these grounds one might consider these national data estimates as fairly conservative.

Certainly research is needed regarding professional issues that result in the decision to hospitalize someone (Kiesler, in press; Mechanic, 1981). This discussion does not seek to assign professional blame. Insurance incentives often allow no other option (Kiesler, 1981a, 1981b); the patient's family is often the most important force behind the hospitalization (Mechanic, 1980); there is perceived administrative pressure to fill hospital beds, and since mental patients stay longer than other patients, hospital administrators find them a financially stable subset of patients to maintain. Physicians often hospitalize people for mental disorders either because they see no alternative, they are uncertain of what else to do, they wish to observe the patient for a few days, or they wish the patient's activities to be tracked more closely by paraprofessionals. The general set of activities leading to mental hospitalization (including professional judgment; treatment during the period immediately following hospitalization; the self-fulfilling prophecy of defining oneself as mentally deranged; and variables which lead, correctly or incorrectly, to a professional's judgment that certain types of patients need hospitalization) needs to be investigated directly and thoroughly. Kiesler (1982) describes several studies in which there was significant resistance from professional staff to the notion of alternative treatment. Indeed, if one is convinced that mental hospitalization works and alternative treatment does not, it can be seen as a matter of professional ethics to oppose anything but mental hospitalization.

Mosher and Menn (Note 4) discuss factors promoting the resistance to change of policies implicitly supporting mental hospitalization. They point specifically to the zeitgeist of the medical model, with its emphasis on "illness" and drug treatment, in which hospitals play a central conceptual role. Further, they suggest, the zeitgeist influences fiscal intermediaries to such an extent that no third-party payers in the United States are willing to underwrite alternative modes of care.

Mosher (1982) describes the most revolutionary approach to system change. In 1978, Italy passed a law requiring that no new patients be admitted to large state-run hospitals, that the hospitals be phased out, that patients not be involuntarily hospitalized in such facilities, and that community-based facilities be established in each geographic area. Although some problems of implementation remain, Mosher (1982) gives a very positive evaluation of the first years' experience: "1) an 18% decrease in the number of inpatients; 2) a 60% decrease in compulsory admissions; 3) little evidence of 'dumping'; 4) no increase in suicide or violent crimes by former patients; and 5) no appreciable difference in admissions to private psychiatric hospitals" (p. 202). The Italian experience appears very promising as a model for a national policy emphasizing noninstitutionalization and alternative care.

Various sets of data regarding attribution theory, attitude change regarding involving issues, and judgment and decisions under uncertainty all suggest that professionals develop strongly held beliefs about mental hospitalization that are not empirically based but at the same time are extremely difficult to change. Psychologically, one can expect resistance to change and aroused reaction to an affect-laden issue. Mental hospitalization, partly because of its long history and partly because of its perceived integration with health policy, appears to be one of those issues.

Dispassionate discussion of the pros and cons of mental hospitalization is difficult. One can expect for a variety of reasons that it will be difficult to change national policies related to mental hospitalization. Certainly the scope of policies that need be changed is sufficiently broad to make the task difficult even if the issue were less affective in nature. Indeed, perspectives are so substantially different on this important area that the debate often centers on what is knowledge.

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# COMPENSATION AND BENEFITS

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## Health Care Cost Containment

Three areas of continually accelerating costs for most organizations are employee health benefit programs, psychological/psychiatric related workers' compensation claims, and disability retirements. This article describes actions taken by the city of Redondo Beach which have significantly reduced or stabilized our costs in these areas. In fact city health insurance premiums have remained constant for fiscal years 1979 through 1981, while the medical care component of the consumer price index has increased annually by 12-15%. Additionally, our group health insurance plan has generated $160,000 in dividend reserve that should offset any needed premium increases for two more years.

### Mandatory Second Opinion

The first action was a policy change which required all eligible employees and dependents to obtain a second opinion before undergoing elective surgery. In most cases, patients have been referred to surgeons whom they did not know for second opinions. The city of Redondo Beach adopted this policy in July 1979.

Requiring second opinion for elective surgery has created an opportunity for employees who have desired such a safeguard, but have not wanted to inform their personal physicians of any doubt or lack of trust in the diagnosis given. Needed dollars have been saved because second opinions have led to fewer surgeries. Further, surgical benefits are cut by 50% if employees refuse to get a second opinion.

A second action of the city was to raise the deductible an employee or family must incur before the health plan provides all benefits. Thus, a single employee or an employee and one dependent must now incur $100 worth of health care costs before the city's medical insurance can be used. The city recognized the fact that inflation had eroded the previous $50 calendar-year deductible, and lessened the employees proportion of participation, while the city had continued to absorb premium increases.

### Additional Benefit

A third change was the inclusion of the California Psychological Health Plan (CPHP) in September 1979. CPHP provides access to outpatient psychological and psychiatric services at little or no cost to the employee. This action was intended to help reduce or stabilize medical insurance premiums, provide a new and necessary benefit at a low cost, and promote the general well-being and productivity of all city employees.

CPHP is the first statewide, prepaid medical health care program to be licensed in the state of California. It is essentially a closed panel program. Panel providers are licensed psychologists and psychiatrists who have contracted with CPHP to provide mental health care services to subscribers, subject to review by a Professional Standards Management Committee comprised of peers. Each panel provider receives a flat rate of $50 per private session and $25 per group session.

Reimbursement to nonpanel providers is 50% of the panel allowance, with a $500 calendar-year maximum.

### Professional Assistance

Recent state and national studies have suggested that between 50% and 80% of complaints heard by physicians either have no organic base or have a significant emotional component to them. As such, continued treatment by a physician generally does not contribute to the resolution of the problem, and adds unnecessarily to the rising cost of health care. The alternative — consultation and treatment by a qualified psychiatrist or psychologist — is seldom pursued by a troubled employee, primarily due to the cost of such treatment. The benefit previously subscribed to only provided $10 per vist for outpatient psychological/psychiatric treatment.

CPHP provides employees with an opportunity to obtain professional assistance for "personal problems" on a confidential basis. Participation in the program is voluntary and may be initiated only at the employee's option. Additionally, the city does not have access to the names of employees who decide to use the plan. Employee education, through orientation sessions and written materials provided by CPHP, have helped to inform employees and their dependents of the program promote usage.

CPHP is available only in conjunction with group welfare programs at a set monthly cost per family unit. This one composite rate provides benefits for all employees only. When integrated into an ongoing health and welfare plan, the prior outpatient benefits for psychological/psychiatric treatment are deleted and CPHP assumes the responsibility for outpatient mental health benefits. Drugs and in-hospital mental health benefits remain the responsibility of the basic health plan.

## Management Concerns

The city's initial interest in CPHP was influenced by several factors. First, a personnel task force comprised of key department heads and staff had suggested that the city either consider providing psychological benefits to public safety employees or retain a psychologist for use on an as needed basis. This interest was in part sparked by three successive disability retirements for psychological reasons, the high incidence of family problems among safety employees, and increasing concern over a newly recognized phenomenon known as "paramedic burn-out."

Second, the unique stresses and strains of public employment were accentuated in the post-Proposition 13 period as employees found themselves working in new positions with different responsibilities and new sets of constraints. Finally, the city was concerned with the rising cost of health care and was impressed with the premium stabilizing effect that CPHP had shown on group medical plans in other jurisdictions.

## Long-term Effects

Two years after the implementation of CPHP, city data indicates that employees have used the services of the plan at a greater rate than originally anticipated. Some 14% of eligible employees and their dependents received services from September 1, 1979, through June 30, 1981. The average utilization rate among all CPHP clients is approximately 6-8%.

While it is impossible to identify a direct cause and effect relationship, the period of time during which CPHP has been a part of Redondo's health benefit program has paralleled an unusually stable experience under the regular group medical plan. The stabilization of health insurance premiums and the generation of a sizeable dividend reserve have already been mentioned. Budget savings are estimated at more than $200,000 during the past three years, thereby freeing scarce financial reserves for appropriation to other needed programs and projects.

Another interesting trend during the same period was a drop in the rate of absenteeism due to sickness, from 3.0% to 1.6%. Also, only one public safety employee was granted a valid psychiatric/psychologically-based disability retirement, and there have been no further applicants for such retirements. □

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RICHARD L. GRAVES AND JANICE L. HASTRUP

# *Psychological Intervention and Medical Utilization in Children and Adolescents of Low-Income Families*

*The present investigation studied the effect on medical utilization when psychological care was provided to a sample of children and adolescents whose low-income families were members of a completely subsidized health program. Comparisons of medical visits were made over a 2-year period for three groups: a treatment group of registrants receiving psychological services; a control group matched with the treatment group according to age, sex, ethnicity, as well as medical utilization and psychological distress; and a group matched only by age, sex, and ethnicity. Results indicated that registrants who received psychological treatment had significant decreases in overall medical utilization, whereas there were no decreases in the other two groups. These findings are consistent with earlier research but extend the pattern of results into younger populations as well as low-income families.*

Pressing needs from two directions, one economic and the other human services, are converging on an area of research that has critical implications for the health delivery system in this country: the impact of psychological intervention on medical usage. Rapidly spiraling medical costs are a major economic concern at the same time that inadequate health care is being provided because of a limited focus on treatment of "medical" problems. Psychological services within a health plan not only decrease excessive medical utilization by some members but also meet patient needs not addressed by the medical service (Cummings, 1977).

The investigators who initiated research in this area were Follette and Cummings (1967). Their work was conducted at Kaiser-Permanente, a private, prepaid health plan in northern California. They found significant reductions in medical usage after psychological treatment for a treated group, with no reductions for an untreated comparison group. The reductions continued in each of the 5 years of follow-up.

Regier, Goldberg, Burns, Hankin, and Hoeper (Note 1) investigated possible "medical offset" savings in four different health care programs: an urban prepaid group practice in Maryland; a rural comprehensive group practice in Wisconsin that had both a prepaid program and a fee-for-service program; and an urban subsidized fee-for-service program in Boston. These investigators found that of patients judged to need mental health treatment, those who were treated had a 20%–30% lower medical utilization rate than those who were not treated. The significance of this research is that reductions were found both for a rural population and for an urban poor population.

Rosen and Wiens (1979) found 35%–40% reductions in medical usage for two outpatient groups at the University of Oregon: One received both psychological evaluation and treatment, the other evaluation only. Neither a "referral not kept" group nor an unreferred group showed such decreases.

In a major review of the research, Jones and Vischi (1979) summarized 27 studies of the effects of mental health, alcohol, and drug abuse treatment on medical utilization.

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Reductions in medical usage of 5%–85% were reported in 12 of the 13 mental health studies and 20%–69% in 12 investigations of alcohol abuse treatment; similar findings were reported in two drug abuse studies.

In an extensive analysis of the medical usage research, Schlesinger, Mumford, and Glass (1980) arrived at three major conclusions. First, studies indicate from .5% to 86% of the patients seen in general medical settings have some emotional illness. Second, the results of 475 outcome investigations indicate that contrary to Eysenck (1952), psychotherapy is effective. Third, the "medical offset" literature and experimental investigations on treatment of alcoholism, asthma, and surgical recovery indicate that there is at least a 14% decrease in excessive medical utilization following psychological intervention.

## Method

The present investigation extended the research into two areas: completely subsidized health programs and programs for children and adolescents. Previous research has studied health plans involving partial (if not total) consumer payments, and the majority of the prepaid plans involved middle-class samples. Only Rosen and Wiens (1979) included significant numbers of children, but their data were not analyzed by age groups.

### SETTING

The health care program studied is one of four comprehensive neighborhood clinics for children and adolescents in Dallas. The clinic serves 3,500 children of mixed ethnicity: Mexican American, black, and Caucasian. Living in the clinic's cachement area automatically qualifies a child or adolescent for completely subsidized outpatient health care. Services provided by the clinic consist of medical, psychological, dental, nursing, and social work as well as nutritional assistance.

### REFERRAL PROCESS

Clinic registrants in need of psychological services are referred by either the clinic

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THE AUTHORS WOULD LIKE *to thank Sandra McEntuff for typing this manuscript and Linda Graves for her valuable editorial assistance.*
THIS ARTICLE IS BASED *on a paper presented at the annual meeting of the Southwestern Psychological Association, New Orleans, Louisiana, April 1978.*

REQUESTS FOR REPRINTS *should be sent to Richard L. Graves, 2700 Second Avenue, Lake Charles, Louisiana 70601.*

Table 1: Clinical Data for Subjects Referred to Psychology Service

| Age (years) | Referral source | Presenting problem | Type of intervention[a] | Number of sessions |
|---|---|---|---|---|
| 8 | Social worker | Tantrums | Parent/child | 1 |
| 5 | Social worker | Fearfulness, immaturity | Parent/child | 1 |
| 10 | Teacher | Learning difficulty | Parent/child | 1 |
| 9 | Teacher | Tantrums, dizziness | Parent/teacher/child | 1 |
| 7 | Teacher | Fears, overactivity | Family/teacher | 2 |
| 9 | Pediatrician | Psychomatic chest pains | Family (SP) | 2 |
| 5 | Pediatrician | Encopresis, discipline | Parent/child | 2 |
| 11 | Pediatrician | Psychosomatic stomach pains | Family | 2 |
| 7 | Pediatrician | Stuttering | Family | 2 |
| 12 | Teacher | Withdrawal | Teacher | 3 |
| 9 | Self (parent) | Withdrawal | Family | 3 |
| 4 | Social worker | Fears, enuresis, encopresis | Family | 4 |
| 14 | Pediatrician | Enuresis | Parent/child | 5 |
| 6 | Teacher | Withdrawal, crying | Family/teacher | 6 |
| 8 | Self (parent) | School failure | Parent/child | 8 |
| 1 | Pediatrician | Breathholding | Family (SP) | 8 |
| 6 | Social worker | School phobia | Parent/child | 8 |
| 6 | Pediatrician | Retardation, disruptive behavior | Family/teacher | 8 |
| 8 | School nurse | Encopresis | Family | 10 |
| 6 | Teacher | Stealing, discipline | Parent/teacher/child | 11 |
| 11 | Pediatrician | Enuresis | Parent/child | 14 |

*Note.* SP = single parent.

[a] Parent/child involved the mother in a two-parent home. Family included both parents or the mother in a single-parent home.

pediatrician or the social worker. It typically results from a patient's request for help for a problem involving a child. Teachers from the area elementary schools also refer children for school-related problems. Clinical data for the children studied are included in Table 1.

## CLINICAL PROCEDURES

Referrals to psychology were handled by two nonminority PhD psychologists, who also carried cases at the three other clinics in this community health care program. Supervision was provided by a psychology service chief, a PhD with several years experience with this low-income minority population.

The therapeutic orientation was an active, problem-solving approach, based on behavioral and family systems theories, which meant involving those most related to the problem, including parents, problematic child, siblings (if needed), and possibly the teacher. Interventions were initiated during the first contact with the family, and usually no formal testing was conducted. This approach was effective with unsophisticated, crisis-oriented families. The nonminority psychologists' efficacy seemed to be enhanced by their identification with the community health clinic and its many minority staff members.

### SELECTION AND CONTROLS

Medical utilization rates over a 2-year span were obtained from clinic records of the treatment group and two control groups. Potential treatment group subjects were clinic registrants who had received psychological treatment at the clinic from October 1975 through May 1976. Of 58 referrals during the 8-month period, 4 were adults, 14 had been seen previously by a clinic psychologist, 12 had incomplete medical records, and 7 never kept the initial appointment. The remaining 21 subjects composed the treatment group.

Two samples of 21 registrants each were selected to form two control groups. Previous findings suggested that individuals having psychological problems are high users of medical services. Therefore, a comparison group with high medical usage should be utilized. Also, since no true randomization can be done in this type of archival research, a criteria is needed to control for psychological referral. At some point the treatment group subjects were defined as having a psychological problem; whereas unreferred high-utilizer controls were not so defined. Thus, some matching in terms of *psychological distress* was needed. To accomplish this matching, a Psychological Distress Scale (Table 2) was created for children and adolescents, similar to that employed by Follette and Cummings (1967) for adults.

This scale was created by cataloging frequently noted problems in the medical charts of registrants referred for psychological services. These problems were then ranked according to judged severity along a 3-point distress scale prior to selecting the matching

Table 2: Psychological Distress Scale With Weights

| Mild distress (+1) | Moderate distress (+2) | Severe distress (+3) |
|---|---|---|
| Skin disorders (impetigo, rashes, scabies, lice) | Anemia | Asthma |
| Appetite or diet deficiency | Abdominal pain | Recurring headaches[b] |
| Wears glasses | Accidents (burns, sutures, abrasions, lacerations | Encopresis |
| Excessive dental visits[a] | Recurring bronchitis, tonsilitis, conjunctivitis, gastroenteritis, otitis, URI, UTI[b] | Truancy |
| Medical noncompliance | Hyperventilation | Functional diagnosis |
| | Overanxious parent | Seizure disorder |
| | Headache[c] | Electroencephalogram referral |
| | | School or home behavior problem |
| | | Retardation |
| | | Learning problem |
| | | Child abuse |
| | | Obesity |
| | | Developmental delay |
| | | Speech problem |

*Note.* URI = upper respiratory infection. UTI = urinary tract infection.
[a] More than two per year. [b] More than one per year. [c] One per year.

Table 3: Subject Characteristics by Groups

| Group | Sex | Ethnicity | Age | Medical visits—pre | PD score |
|---|---|---|---|---|---|
| Treatment | 13 M | 16 MA | 7.7 | 5.8 | 5.1 |
| | 8 F | 3 CAU | (1–14) | (0–19) | (0–19) |
| | | 2 BL | (2.96) | 4.85) | (4.66) |
| Matched control | 13 M | 19 MA | 8.0 | 4.7 | 4.1 |
| | 8 F | 1 CAU | (2–15) | (1–11) | (0–13) |
| | | 1 BL | (3.20) | (2.74) | (2.95) |
| Random control | 13 M | 17 MA | 8.4 | 2.3 | 2.2 |
| | 8 F | 3 CAU | (2–15) | (0–8) | (0–10) |
| | | 1 BL | (3.20) | (2.47) | (2.46) |

*Note.* The statistics in each category are mean, range, and standard deviation. MA = Mexican American, CAU = Caucasian, BL = black, M = male, F = female, PD = psychological distress.

subjects. Treatment group subjects were given psychological distress scores by summing the points earned for each problem noted in the medical chart for the year preceding referral. This score was used in the matching process to select subjects for a matched control group. Each control subject was matched with a treatment subject on five variables: distress score, number of medical visits in prior year, age, sex, and ethnicity.

These two "abnormal" groups provide a basis for comparing treatment versus no treatment. Also, a random control group of clinic registrants would provide a comparison of treated abnormals versus average subjects in the health clinic population. To provide this latter comparison, the random control group was formed by including clinic registrants matched only by age, sex, and ethnicity with the treatment group subjects. The compositions of the three groups can be seen in Table 3.

The 2-year span for each member of the two nonreferred control groups was identical to the time period for the treatment group subject with whom this nonreferred subject was matched. For example, if a child was referred for psychological services on March 12, 1976, the year before and the year after this date were the periods studied for that child and for the matched control subject and the random control subject who were paired with the particular treatment group child.

## Results

Treatment group subjects showed a significant reduction in clinic visits, from a mean of 5.8 in the year preceding referral to a mean of 3.7 in the year following referral: $F(1, 20) = 7.26, p < .025$. A similar reduction did not occur in the visits of the two control groups. In fact, the medical visits of the matched abnormal control group increased slightly, but not significantly, from a mean of 4.7 to a mean of 6.1 visits: $F(1, 20) = 2.03, p < .10$. There was essentially no change over time for the random control group, with means of 2.3 and 2.1 in the 2 years studied. A schematic of these data is shown in Figure 1.

In this study, as in previous studies, patients referred for psychological treatment (and patients with high-rated psychological distress) were significantly higher medical utilizers than a random sample of nonreferred patients. Using Newman-Keuls tests, both the treatment group and the matched control group differed significantly from

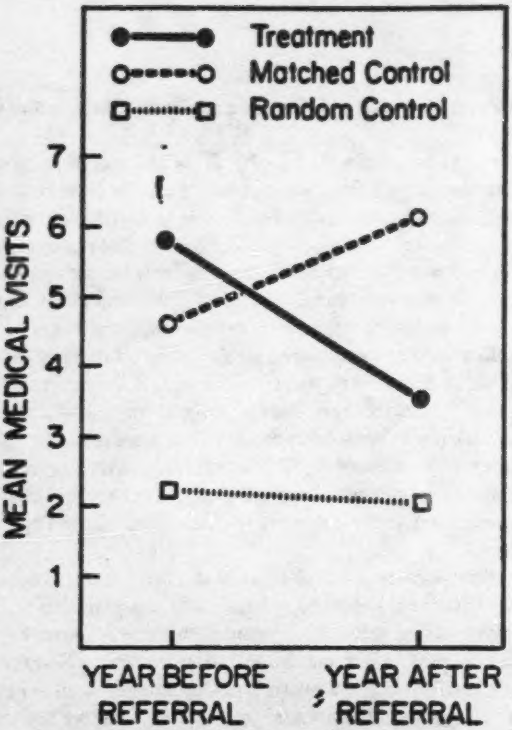

Figure 1. Mean medical visits per group for the year before and the year after the psychological referral date.

the random control group during the prereferral year ($p < .05$). In the year after referral, however, treatment group subjects did not differ significantly from random controls. The matched control group subjects (i.e. high-distress/utilizers), on the other hand, maintained their higher level of medical usage in the year following the referral date and significantly differed from the random controls ($p < .05$).

## Discussion

The results of this study indicate that psychological treatment of children and adolescents in a completely subsidized health service program results in a significant reduction in their medical utilization. This reduction of 36% is similar in magnitude to those of earlier investigations and suggests the possibility of considerable medical cost savings, as psychological services become integrated into general health care programs.

In one of the plans studied, Regier et al. (Note 1) found that the total cost per patient for mental health care decreased from $120 to $40, as a result of savings in general medical expenses. Thus, although psychological services may not quite completely pay for themselves via reductions in medical services, they can result in substantial savings while providing more appropriate care for emotionally distressed health plan members.

The presence of such savings in middle-class health plans has been documented. The present study suggests that these "offset" savings would also be present in completely subsidized plans, a finding of considerable significance to health planners now in the process of designing national health care policy. The present findings concerning the efficacy of psychotherapeutic services with low-income patients are consistent with those of Edwards, Greene, Abramowitz, and Davidson (1979), who also found no differences in length of treatment among patients from differing income levels.

The fact that medical utilization decreased after a small number of therapy sessions is another important finding of the present study. Follette and Cummings found medical usage reductions over 5 years for three therapy groups: (a) one session only, (b) brief therapy (2–8 sessions), and (c) long-term therapy (9 or more sessions). Only the brief therapy group, however, manifested significant reductions in the 1st year after therapy. To further examine the impact of length of therapy, the treatment group data in the present study were categorized into two subgroups: one session only and brief therapy (2–14 sessions).

There was a significant decrease in medical visits of the brief therapy subjects, ranging from a mean of 5.6 in the year preceding referral to 3.0 the year after referral ($p < .01$). However, the one session only subjects showed no decrease, with a mean of 6.8 medical visits in both the year before and the year after therapy. This finding differs from those of Rosen and Wiens and Follette and Cummings. It may be that one session contacts with younger populations are less impactful, that we are seeing a different population of patients in these sessions, that low-income patients are not impacted by only one session, or that other, as yet unidentified, factors were operative.

Two factors limit the generalizations to be drawn from this study. First, the number of subjects is substantially smaller than previous studies. Second, the time span in the present study was shorter than in the major studies. These shortcomings are inherent in the setting studied. There was a small clinic population, and the mobility of the population made long-term follow-up impossible.

As psychologists continue to demonstrate impacts on the broader aspects of health care, the profession will undergo further change. Psychologists, as Schofield (1976) views the field, are "health professionals," and they are becoming increasingly involved in problems not traditionally defined as psychological. This change has already begun in many areas, for example, the new fields of pediatric psychology and health care psychology (or behavioral medicine). However, as the profession changes, so also must the approach to health care. There is a greater need, as Rosen and Wiens (1979) suggest, for close collegial cooperation of physicians and psychologists, to the extent of a partnership treatment approach rather than a referral approach. Rosen and Wiens described a headache clinic at the Oregon Health Science Center, with a psychologist and neurologist as codirectors. The partnership reported in this article, which consists of health teams composed of medical, psychological, and other health personnel, all with continual, coequal input into the health care of each child, is another example. The significant aspect of these newer cooperative efforts is the inclusion of psychologists at or near the patient's entry into the health care system rather than as a last resort. Psychological intervention should become a more and more integral component of health delivery networks.

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Chairman **Jacobs**. Thank you.

Ms. Wineburgh, when you spoke of your first case you spoke of the psychiatrists working for $95 an hour, and you found another one at $45, and your own services I think they dwindled to a visit a week for several months.

Would you care to say for the record what your services were in costs?

Ms. **Wineburgh**. My services?

Chairman **Jacobs**. You don't have to but it might round out the picture.

Ms. **Wineburgh**. I charged her $30 an hour.

Chairman **Jacobs**. Thirty dollars.

Ms. **Wineburgh**. The psychiatrists saw her twice.

Chairman **Jacobs**. We do write the income tax laws and——

Ms. **Wineburgh**. And I pay my taxes, yes.

Chairman **Jacobs**. So be careful.

Ms. **Wineburgh**. I have a very good accountant. The psychiatrist was $95 a session, a geriatric psychiatric specialist. The one I referred her to was a psychoanalytic M.D., who specializes in medication.

He charged $40 an hour. That was one visit.

Chairman **Jacobs**. Also your comment about the dog passing elicits smiles; I am a well-known canine fancier. So I didn't consider it silly after all.

Thank you very much for your testimony.

[The following was submitted for the record:]

DEPARTMENT OF DEFENSE
OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
AURORA COLORADO 80045

FEB 7 1983

ISS

Mr. John E. Kern
Minority Health Counsel
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Kern:

The attached comments and supporting documents are supplied per your January 27, 1983 request, in response to the testimony by Mr. Clarence J. Martin and Dr. Eugene E. Levitt.

As our response indicates, while certain CHAMPUS mental health data may have been misinterpreted by the Association for the Advancement of Psychology, the data as presented are, in fact, entirely valid. The intent of the User's Guide for Psychiatric Reports For Care Provided Under the CHAMPUS Program in Fiscal Year 1980, which is the source of the data in question, was not to provide a detailed, comprehensive analysis of the reports, but rather to provide overall guidance to those who wished to analyze the mental health data in a manner appropriate for their needs. Consequently, only summary analysis primarily for use by CHAMPUS program management was provided in the User's Guide.

It was unfortunate that some of the analysis provided by OCHAMPUS was subject to misinterpretation and I regret that the Association for the Advancement of Psychology found the data in question objectionable. We will make every effort to eliminate this potential for erroneous interpretation of the CHAMPUS mental health data in the future reports released to the general public.

If I may be of further assistance, please let me know. We will gladly furnish any additional information which you or the Committee on Ways and Means may desire.

Sincerely,

Theodore D. Wood
Director

Enclosure

Comments in response to testimony provided by Mr. Clarence J. Martin and Dr. Eugene E. Levitt of the Association for the Advancement of Psychology to the Committee on Ways and Means

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Because of the interest in the utilization of the mental health care benefits under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) at many levels of government and the private sector, a comprehensive series of nineteen reports comprising 565 pages of data was produced. The CHAMPUS mental health reports were first generated in 1982 for Fiscal Year 1980, and will be produced on an annual basis for each succeeding fiscal year. These reports include detailed data regarding the mental health care rendered to Department of Defense beneficiaries as well as some non-Department of Defense beneficiaries.

Due to the voluminous nature of these reports, a user's guide was developed to serve as an aid for understanding them and their interpretation by potential users of the data. As part of the User's Guide for Psychiatric Reports for Care Provided Under the CHAMPUS Program in Fiscal Year 1980 (User's Guide), a section was devoted to general, summary type analysis of the data contained in the broader reports. The intent of this analysis was not to provide a detailed examination of the data, since there are virtually countless ways to examine the data depending on the needs or desires of the user. Instead, the focus was upon general trends and overall findings. Of major interest to program managers and policy-makers at OCHAMPUS is the overall cost impact on the program of the mental health benefits and the quality of care rendered.

It was the intent of the preparers of the User's Guide to leave detailed analysis to individuals or groups such as the American Psychological Association to work with as they wished.

In specific response to the comments made by Mr. Martin and Dr. Levitt regarding the quality of the CHAMPUS mental health data as well as their analysis and presentation, the following observations are provided for your consideration.

1. Regarding Table 12 of the analysis presented in the User's Guide, the data therein are intended to show only the most frequently used mental health procedure for several types of mental health care providers (i.e., attending physicians, psychiatrists, psychologists, social workers, therapists and others) and the frequency of visits, the percent of the total number of procedures (visits) provided by the respective type of practitioner and the average amount paid per visit for the procedure listed in the table. These data are not intended to represent an analysis of any one procedure across all types of practitioners. Nor are they intended to present data regarding the

Enclosure

average amount paid per visit for a particular type of procedure, such as individual psychotherapy, 45-60 minutes in duration, which may involve more than one procedure code in the detailed reports. (Please see TAB A)

2. Realizing the difficulty in comparing differing procedures across all types of practitioners, and thus encountering the problem of comparing "apples to oranges," no such analysis was prepared. Even within the same procedure code there may be variations in the type of care provided by different types of practitioners based on the discipline and training of the provider.

   However, had such analysis been conducted, using the average amount paid per visit for all mental health procedures combined and all mental health diagnoses combined, CHAMPUS FY 1980 data would still show that psychologists received, on the average, higher payments per visit than psychiatrists or any other type of practitioner, for both inpatient and outpatient visits. (Please see TAB B)

   Obviously, at this macro-level of analysis, the conclusions that can be drawn are limited because of the tremendously wide variety in the types of mental health procedures received by the beneficiary in terms of the length of treatments or tests, the types of treatments, the number of individuals involved in treatment and the nature of the mental health disorder. For this reason, OCHAMPUS did not perform such an analysis or attempt to make meaningful judgments from these data.

3. The "APA Reanalysis and Correction of CHAMPUS User's Guide for Psychiatric Reports (July 1982)" presented as part of Dr. Levitt's testimony is one approach to comparing a variety of data for psychiatrists and psychologists. Their presentation appears to be valid and their conclusions sound regarding the average amount paid per visit for various subgroupings of mental health procedures.

   Specifically, their approach to analyzing the data by grouping various treatment (procedure) codes under different categories of treatment, such as "Individual Treatment 45-60 minutes," supports their premise that in terms of the average amount paid per visit for similar types of treatment, psychologists sometimes received less than psychiatrists, depending on whether the setting was inpatient or outpatient.

   For example, for the treatment category "Individual Treatment 45-60 minutes," psychologists were paid on the average, approximately $1.00 less per outpatient visit than were psychiatrists. For inpatient visits for the same category of treatment and groups of procedures, psychologists received, on the average, approximately $5.50 less per visit than psychiatrists.

However, their analysis refers to the CHAMPUS data as claims reports, and their tables are erroneously titled "CHAMPUS ... Mental Health Service Claims Controlled Comparisons: Session Length by Session Type." The data used in their analysis are, in fact, visit data from the CHAMPUS mental health reports and are not claims data as they purport. It should be noted that the CHAMPUS mental health reports do not contain any claims data. It appears that the APA confused visits for claims data, and as such it is inaccurate. Their reanalysis of the CHAMPUS mental health data should be correctly labeled so as not to mislead your committee or any others who may use their reanalysis of CHAMPUS visit data.

This is an example of how even sophisticated data users such as those on the staffs of the American Psychological Association and the Association for the Advancement of Psychology can misinterpret the data from secondary sources, and inaccurately misrepresent them in their own analyses.

4. In question number six posed to Mr. Martin the statement was made that "Committee staff verified the attached CHAMPUS data with program officials and confirmed that for outpatient psychotherapy of 50 minutes duration the average amount paid per visit to psychiatrists in FY 1980 was $50.82. For psychologists, in FY 1980 the average amount paid per 45-50 minute visit for psychotherapy was $55.75." To further clarify our position, we would like to add that we presume the reference in the testimony to "the attached CHAMPUS data" refers to Table 12, page 42 of the User's Guide entitled "Most Frequently Used Procedures for Each Type of Practitioner and Average Amount Paid Per Visit (Outpatient Professional Services - Report 2)". Further, the amount of $50.82 paid to psychiatrists refers to the average amount paid per visit for procedure code number 90805 only. For psychologists, the average amount paid per visit of $55.75 refers to procedure code number 92803 only. These distinctions are made because there are presently several psychiatric and psychological procedure codes in the CHAMPUS data base for psychotherapy of 45-50 minutes duration. OCHAMPUS is, however, phasing into a system of uniform procedure reporting (to be completed by 1984) which will alleviate this type of confusion.

5. The following statement was made by Mr. Martin in his testimony presented in response to question number six: "...Although the table does, in fact, represent valid data, the sense it conveys in entirely wrong." Further, in the reanalysis performed by the American Psychological Association in December 1982, the statement is made on page 1, second paragraph, that "The data was (sic) presented in a way that made it appear that psycholo-

gists and psychiatrists were being compared on a cost-per-visit basis. While it was not the intention of CHAMPUS to make this comparison, their manner of data presentation encouraged the comparison and misinterpretation of the cost figures."

The validity or accuracy of the data as presented in Table 12 of the User's Guide is not being called into question. It is the interpretation of the data and the manner of presentation that is being faulted by the AAP and APA. Because of certain limitations of the CHAMPUS data for these reports as discussed in the User's Guide, no attempt was made by the CHAMPUS staff to conduct an analysis on a cost-per-visit basis of the amount paid to various types of mental health care providers. The detailed CHAMPUS mental health reports (not the User's Guide) do allow one to analyze the data in this manner. However, it is extremely important that the user understand the caveats and assumptions regarding these data which are thoroughly described in the User's Guide.

In conclusion, I would like to suggest that in order to prevent any misunderstanding of the CHAMPUS mental health data, those wishing to conduct their own analysis of the data should obtain a copy of the User's Guide to these reports and become knowledgeable about the limitations of the data and how to interpret the reports. In addition, should anyone have questions about the report parameters or any of the data contained within the reports, the staff at CHAMPUS would welcome the opportunity to answer any questions or to clarify the data and their interpretations. It is my hope that through this process, further misunderstandings can be avoided.

TAB A

## Table 12. Most Frequently Used Procedures for Each Type of Practitioner and Average Amount Paid per Visit (Outpatient Professional Services - Report 2)

| Type of Practitioner | Procedural Code No. | Description | Frequency | Percent of Total Procedures* | Average Amount Paid Per Visit |
|---|---|---|---|---|---|
| Attending Physicians | 92803 | Psychotherapy, adult or child, 45-50 minutes, in office | 14,417 | 30.9% | $49.73 |
| Psychiatrists | 90805 | Psychotherapy - verbal, 50 minutes | 163,688 | 44.4 | 50.82 |
| Psychologists | 92803 | Psychotherapy, adult or child, 45-50 minutes, in office | 129,562 | 49.8 | 55.75 |
| Social Workers | 03030 | Individual Counseling | 96,448 | 55.8 | 44.77 |
| Therapists (All Types) | 90805 | Psychotherapy - verbal, 50 minutes | 62 | 75.6 | 43.47 |
| All Others | 90805 | Psychotherapy - verbal, 50 minutes | 47,498 | 59.9 | 43.24 |

* Percentages are based on the total number of psychiatric visits provided by the type of practitioner indicated in Column 1.

SOURCE: User's Guide for Psychiatric Reports for Care Provided Under the CHAMPUS Program in Fiscal Year 1980

TAB B Table 2. Average Amount Paid per Visit by Type of Practitioner All Psychiatric Procedural Codes Combined

| Type of Practitioner | Inpatient (Report 1) | Outpatient (Report 2) |
|---|---|---|
| Attending Physicians | $34.57 | $42.34 |
| Psychiatrists | 43.12 | 48.69 |
| Psychologists | 49.78 | 52.08 |
| Social Workers | 32.00 | 38.64 |
| Therapists (All Types) | - | 42.94 |
| All Others | 36.56 | 40.77 |

Table 3. Average Amount Paid per Visit by Type of Practitioner All Psychiatric Diagnoses Combined

| Type of Practitioner | Inpatient (Report 3) | Outpatient (Report 4) |
|---|---|---|
| Attending Physicians | $34.54 | $42.46 |
| Psychiatrists | 43.00 | 48.72 |
| Psychologists | 49.82 | 52.12 |
| Social Workers | 31.93 | 38.68 |
| Therapists (All Types) | - | 43.87 |
| All Others | 36.51 | 40.64 |

SOURCE: User's Guide for Psychiatric Reports for Care Provided Under the CHAMPUS Program in Fiscal Year 1980

Chairman JACOBS. The next panel consists of the American Nurses Association, Dr. Carter; and the American Occupational Therapy Association, Mary E. Peters; and the American Psychiatric Association, Dr. John Bowman.

## STATEMENT OF ELIZABETH CARTER, R.N., CHAIRMAN, DIVISION OF PSYCHIATRIC AND MENTAL HEALTH NURSING PRACTICE, AMERICAN NURSES' ASSOCIATION, INC.

Dr. CARTER. Thank you, Mr. Chairman.

Chairman JACOBS. I don't think anybody will beat Mr. Schmidt, but the second prize is up for grabs.

Dr. CARTER. I am Elizabeth Carter, I am on the faculty of the Columbia University School of Nursing. I also serve as chairperson of the Division of Psychiatric and Mental Health Nursing Practice in the American Nurses' Association.

The American Nurses Association is pleased to present our perspective on the adequacy of medicare/medicaid coverage for the services of mental health specialists, in general, and specifically psychiatric and mental health nurse specialists. Additionally, we wish to comment on the unmet needs for the problems of access to mental health services by medicare and medicaid beneficiaries as well as the qualifications and the range of services provided by psychiatric and mental health nurse specialists.

Current law severely restricts both the types of professionals receiving direct reimbursement for mental health care and services and the setting in which such reimbursed care is delivered. The services of nonphysician providers are reimbursed usually as incident to a physician's services. This clearly discriminates against many qualified mental health providers such as psychiatric nurse specialists.

Consistent with the 1978 report of the President's Commission on Mental Health, the American Nurses' Association supports the creation of a "more comprehensive and coordinated public and private strategy for financing mental health services where payment is based upon the need for care, not diagnosis, and upon the appropriateness of care, not the discipline of the provider."

Additionally, limiting the freedom of choice of the consumer through restrictive reimbursement policies prevents psychiatric nurse specialists from performing the full range of services for which they are qualified through formal education and through experience with non medicare/medicaid populations. Without the full utilization of the skills and abilities of mental health professionals, the unmet health needs of the various populations will remain unmet.

With respect to medicare and medicaid populations specifically, the settings where psychiatric nurse specialists have the potential for the greatest impact on the disparity between met and unmet needs of individuals are those organized settings that are primarily nonacute inpatient facilities or community-based facilities or services.

For it is in facilities such as skilled nursing facilities, community mental health centers, or home health agencies or in the individual's home that appropriate and timely therapeutic interventions can occur that can prevent or deter the need for more extensive or prolonged treatment in a more costly psychiatric or nonpsychiatric setting or context.

Without regard to the type of provider or setting, the quality of the care and services delivered is of utmost importance. Therefore, it is essential that peer review mechanisms or other quality assurance procedures that facilitate the identification and evaluation of the practice decisions of mental health professionals be incorporated into overall changes in coverage.

The President's Commission Report of 1978 indicated that populations underserved by mental health care providers included: children, adolescents, aged, and members of ethnic minority groups, with chronically mentally ill persons being most severely neglected. Rural areas and inner cities were cited as the geographic areas most underserved. There is no evidence to suggest that dramatic changes have occurred since 1978. In fact, with cutbacks in medicaid and other State administered health programs, the situation appears to have worsened.

Conclusions from a survey conducted by ANA Council of Specialists in Psychiatric Nursing indicated that psychiatric and mental health nursing specialists provided needed services to the identified underserved populations.

Ease of access to health care for any population is controlled by several factors. Most pertinent are physical access, including flexibility in the scheduling at the convenience of the client, as well as the actual location of the services, and financial access permitted by the system. Insurance mechanisms define both physical and financial access to the provider. If reimbursement for services is limited to one group of health professionals, this obviously limits the physical access by excluding other health professionals, such as nurses, who can and do provide services in a variety of settings.

Equally important is the limited access by the various populations to the full range of services which nursing can provide. Current coverage leaves many older people not only underserved but inappropriately served.

The minimum level of educational preparation beyond initial licensure as a professional nurse for the psychiatric nurse specialist is a master's degree in psychiatric and mental health nursing with academically supervised clinical practice and study and an increased depth of knowledge in social, biological, and behavioral sciences as well as medical theories of psychotherapy.

The psychiatric and mental health nurse specialist must also meet the eligibility requirements for certification by a national organization. Currently there are about 730 psychiatric and mental health nurse specialists of which approximately 70 focus on the mental health problems of children and adolescents.

Psychiatric nursing is practiced in a variety of settings, from institutions where high levels of teamwork and technology exists to community-based, noninstitutional settings where nurses practice on a highly independent, self-directed basis. Psychiatric and mental health nursing encompasses responsibilities for collaboration and coordination with those who may be working concomitantly with the client and those experts who can enhance the quality of service. In the role of primary care provider, psychiatric nurse specialists assume responsibility for continuous care for individuals and families beginning at the point of the client's entry into the mental health delivery system and extending through the treatment and rehabilitation phase.

In summary, psychiatric and mental health nurse specialists are qualified mental health professionals by virtue of their education and experience and are concerned about, interested in, and willing and able to work with currently underserved populations. Changes in the coverage of mental health professionals under medicare and medicaid which will increase the access of the various populations to mental health professionals should include access to and coverage for this valuable provider, the psychiatric and mental health nurse specialist.

Changes in coverage that promote competition among health care professionals as providers of necessary care and services to the underserved and that include the necessary provisions to assure the quality aspects of care are suggested.

Thank you for the opportunity to present our views. I have presented a somewhat abbreviated version of our statement and I would request the entire statement be part of the hearing record.

Chairman JACOBS. You may think so, but it took 8 minutes and 17 seconds to abbreviate. The rest of the statement will be included.

[The prepared statement follows:]

### STATEMENT OF DR. ELIZABETH CARTER, P.H., R.N., AMERICAN NURSES' ASSOCIATION

The American Nurses' Association is pleased to present our perspective on the adequacy of Medicare/Medicaid coverage for the services of mental health specialists, in general, and specifically psychiatric and mental health nurse specialists. Additionally, we wish to comment on the unmet needs for the problems of access to mental health services by Medicare and Medicaid beneficiaries as well as the qualifications and the range of services provided by psychiatric and mental health nurse specialists.

The American Nurses' Association, the professional association for the nation's nurses, is uniquely qualified to speak to these issues on behalf of psychiatric nurses. The Division on Psychiatric and Mental Health Nursing Practice of the association is the structural unit through which psychiatric nurses accomplish their legitimate responsibilities which include: development of standards of psychiatric nursing practice, delineation of the scope of practice of psychiatric nurses, and certification of psychiatric nurses and nurse specialists. Since 1972, programs to accomplish these functions have been developed, implemented, evaluated, and revised within the association; all programs are currently fully operational.

#### ADEQUACY OF COVERAGE

Current law severely restricts both the types of professionals receiving direct reimbursement for mental health care and services and the setting in which such reimbursed care is delivered. The services of non-physician providers are reimbursed usally as incident to a physician's services. This clearly discriminates against many qualified mental health providers such as psychiatric nurse specialists. Consistent with the 1978 report of the President's Commission on Mental Health, the American Nurses' Association supports the creation of a "more comprehensive and coordinated public and private strategy for financing mental health services where payment is based upon the need for care, not diagnosis, and upon the appropriateness of care, not the discipline of the provider."

The American Nurses' Association believes that any changes in the current coverage of mental health services for Medicare and Medicaid beneficiaries should include the coverage of care and services provided by psychiatric and mental health nurse specialists. The association acknowledges the fact that lack of reimbursement to non-physician providers restricts the consumer's choice of a health care provider. Limiting the freedom of choice of the consumer also limits access to mental health services and serves to diminish rather than promote competition among health care professionals, thus perpetuating the possibility of higher costs for care and services than would occur with more competition in the marketplace. Additionally, limiting the freedom of choice of the consumer through restrictive reimbursement policies prevents psychiatric nurse specialists from performing the full range of services for which they are qualified through formal education and through experience with non-Medicare/Medicaid populations. Without the full utilization of the skills and abilities of mental health professionals, the unmet mental health needs of the various populations will remain unmet.

With respect to Medicare and Medicaid populations specifically, the settings where psychiatric nurse specialists have the potential for the greatest impact on the disparity between met and unmet needs of individuals are those organized settings that are primarily non-acute impatient facilities or community-based facilities or services. For it is in facilities such as skilled nursing facilities, community mental health centers, or home health agencies or in the individual's home that appropriate and timely therapeutic interventions can occur that can prevent or deter the need for more extensive or prolonged treatment in a more costly psychiatric or non-psychiatric setting or context.

Without regard to the type of provider or setting, the quality of the care and services delivered is of utmost importance. Therefore, it is essential that peer review mechanisms or other quality assurance procedures that facilitate the identification and evaluation of the practice decisions of mental health professionals be incorporated into overall changes in coverage. Whether professional practice decisions result in receipt of appropriate, timely, and effective care and services that are of the proper intensity, variety, and duration is of significant concern to the professional providers, facilities, insurers, and, most importantly, to the consumer. Qualitative judgement by peers will require continued growth and refinement of practice of the individual providers and of their respective disciplines.

The cost benefit/effectiveness of a particular type of health care, technology, or service generally receives a great deal of attention particularly during times when a wide variety of ways to curtail the rate of increasing costs are being considered. The limited amount of research evidence to substantiate the cost benefit/effectiveness of the care and services of psychiatric nurse specialists is a fact. In part, this is true because of the low rate of participation of psychiatric and mental health nurse specialists in existing reimbursement mechanisms, of the continued requirement for supervision of "sign off" by a physician in some instances, and of the differences in the rates paid to the variety of mental health professionals for the same service under existing private insurance plans. These factors distort the costs of services provided by any particular mental health professional and prevent the identification of aggregate data that accurately reflects a professions participation in the delivery of an reimbursement for psychiatric care.

The participation of psychiatric nurse specialists in the Civilian Health and Medical Plan for the Uniformed Serices (CHAMPUS) and in the related peer review activities is too recent and too limited to draw conclusions that would be helpful at this time. Collection and analysis of data with respect to reimbursement of psychiatric nurse specialists by private insurers has just begun. We look forward to a future opportunity when we can share this information with you. We hope that this data along with the analysis and recommendations from other studies and projects currently underway, such as the Medicare Mental Health Demonstration Project of the Department of Health and Human Services, will be instructive for reimbursement policy determinations.

### UNMET NEEDS AND ACCESS TO CARE

The President's Commission Report of 1978 indicated that populations underserved by mental health care providers included: children, adolescents, aged, and members of ethnic minority groups, with chronically mentally ill persons being most severely neglected. Rural areas and inner cities were cited as the geographic areas most underserved. There is no evidence to suggest that dramatic changes have occured in the delivery system to improve on these 1978 findings. In fact, with cutbacks in Medicaid and other state administered health programs, the situation appears to have worsened.

Conclusions from a survey conducted by ANA Council of Specialists in Psychiatric and Mental Health Nursing indicated that psychiatric and mental health nursing specialists provided needed services to the edentified underserved populations. They are already deeply involved and concerned with these populations. The impact of the participation of these nurses on the totality of unmet mental health needs of all populations would provide erroneous information due to the small sample size of the survey and to the relatively small universe of psychiatric and mental health nurse specialists. Of significance, however, is the demonstrated interest in and willingness and ability to work with the currently underserved populations.

Ease of access to health care for any population is controlled by several factors. Most pertinent are physical access, including flexibility in the scheduling at the convenience of the client, as well as the actual location of the services, and financial access permitted by the system. Insurance mechanisms define both physical and financial access to the provider. If reimbursement for services is limited to one group of health professionals, this obviously limits the physical access by excluding other health professionals, such as nurses, who can and do provide services in a variety of settings. Equally important is the limited access by the various populations to the full range of services which nursing can provide. Current coverage leaves many older people not only underserved but inappropriately served.

## PSYCHIATRIC AND MENTAL HEALTH NURSE SPECIALISTS

The minimum level of educational preparation beyond initial licensure as a professional nurse for the psychiatric nurse specialist is a master's degree in psychiatric and mental health nursing with academically supervised clinical practice and study and an increased depth of knowledge in social, biological, and behavioral sciences as well as medical theories of psychotherapy. The psychiatric and mental health nurse specialist must also meet the eligibility requirements for certification by a national organization. Currently there are slightly more than 730 psychiatric and mental health nurse specialists who meet this definition. Of this number, the practice of approximately 70 nurse specialists focuses on the mental health problems of children and adolescents.

The American Nurses' Association defines psychiatric and mental health nursing as a specialized area of nursing practice using theories of human behavior as its science and purposeful use of self as its art. It is directed toward both preventive and corrective measures in the treatment of mental disorders. Psychiatric nursing is practiced in a variety of settings, from institutions where high levels of teamwork and technology exists to community-based, noninstitutional settings where nurses practice on a highly independent, self-directed basis. Psychiatric and mental health nursing encompasses responsibilities for collaboration and coordination with those who may be working concommitantly with the client and those experts who can enhance the quality of service. In the role of primary care provider, psychiatric nurse specialists assume responsibility for continuous care for individuals and families beginning at the point of the client's entry into the mental health delivery system and extending through the treatment and rehabilitation phase.

Direct nursing care functions of the psychiatric and mental health nurse specialists include: individual and group psychotherapy, family therapy, screening and evaluation, establishing a therapeutic milieu, conducting health teaching activities, providing support and medication surveillance and responding to client's needs through community action, when appropriate.

In summary, psychiatric and mental health nurse specialists are qualified mental health professionals by virture of their education and experience and are concerned about, interested in, and willing and able to work with currently underserved populations. Changes in the coverage of mental health professionals under Medicare and Medicaid which will increase the access of the various populations to mental health professionals should include access to and coverage for this valuable provider, the psychiatric and mental health nurse specialist. Changes in coverage that promote competition among health care professionals as providers of necessary care and services to the underserved and that include the necessary provisions to assure the quality aspects of care are suggested.

Thank you for the opportunity to present our views.

[Subsequent to the hearing, Mr. Gradison submitted the following questions:]

1. Under the CHAMPUS program where there is considerable experience in paying fee-for-service to psychologists and clinical social workers, recent data show that the average fee paid for a 45-50 minute psychotherapy visit to a psychologist exceeds the average fee paid to a psychiatrist, and in some states the average fee paid to a clinical social worker for a 45-50 psychotherapy visit is as high or nearly as high as the average fee paid to a psychiatrist.

Is there any reason to believe that psychiatric nurses specialists would bill less than clinical social workers or psychologists for similar services?

2. There are thousands upon thousands of nonphysician health professionals providing health services to patients. What criteria should one use to sort out which ones should be paid on a fee-for-service basis and which ones should remain salaried employees? For example, should all RN's be paid fee-for-service? What about LPN's, X-ray technicians, emergency room technicians, medical technologists, speech therapists, respiratory care therapists, and so on? Where does one draw the line?

What would likely happen to health care cost if we paid all health care professionals on a fee-for-service basis?

3. You indicated in your testimony that psychiatric nurse specialists' greatest potential impact on unmet needs would be in organized settings that are primarily non-acute inpatient facilities such as skilled nursing facilities or community mental health centers and home health agencies.

Do you believe that would be true with respect to other mental health practitioners, and if so wouldn't it be less costly if the services were provided by salaried employees of those facilities or agencies rather than reimbursed on a fee-for-service basis.

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AMERICAN NURSES' ASSOCIATION, INC.,
*Kansas City, Mo., January 21, 1983.*

JOHN J. SALMON,
*Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Longworth House Office Building, Washington, D.C.*

DEAR MR. SALMON: This letter includes the response to questions posed by Congressman Gradison in a letter received on December 27, 1982 relative to the December 14 Subcommittee on Health hearing. It is my understanding that this response will become part of the hearing record.

The letter states that there is a relative similarity in the rate of reimbursement for psychotherapy visits by various providers under the CHAMPUS program and questions whether psychiatric nurse specialists will bill less than other providers for similar services? As you are aware, the participation of psychiatric nurse specialists in the CHAMPUS program is recent and the rate of participation at present is relatively low. Whether psychiatric nurse specialist providers will actually bill lower than others for similar services provided in the same or similar locality will be revealed when such data are made available by CHAMPUS. The fact that the health care market does not operate as a true market, fostering competition among health care providers, suggests that the reimbursement rate for the same service could be the same or similar. The goal of including the array of mental health specialists in the reimbursement schemes are to slow the rate of increase of the coverage or usual fee for providers of similar services and, in some cases, to demonstrate the efficiencies of a particular provider group. In some situations fees of psychiatric nurse specialists will be equal to those of other providers; in other situations, fees will be less than that of other providers for similar services.

With respect to the questions posed around fee for service for all health care professionals, and the impact of such a reimbursement strategy on health care costs, the American Nurses' Association believes that the current focus of the Medicare program is provider driven and that, if health care costs are to be changed, the basic focus of the program must be changed. We believe that alternative providers and services should be included in the program as well as an expansion in the benefit package for beneficiaries. Such changes will bring about the scenario referred to in your third question, that is, the delivery of services in organized settings that are not acute inpatient facilities.

Fee for service, in and of itself, is not a bad thing. Who pays the fee for service is a different matter. An organized setting could contract with health care providers on a fee for service basis and could still provide necessary care and services in an economical fashion. This notion of fee for service could be instrumental in holding costs down and is quite different from allowing the provider of services to fill in a blank check that is already signed by the Federal government. It could be possible for an organized setting to contract, on a fee for service basis, for the services of a wide variety of health care personnel as identified in the question. It might be more economical, in fact, for an organized service to contract for services especially when the volume and frequency of services is less than that required for a full-time employee. In the case of organized services, the Federal government's influence of the costs for the organized services would necessarily need to change so that the provision of increased services does not result in escalating costs.

Your understanding that the potential impact by psychiatric nurse specialists on unmet needs of people is in organized settings is correct. Whether other mental health practitioners are similarly inclined must be addressed by those disciplines.

Whether provision of services in organized settings would be less costly when provided by salaried employee as contracted by fee for service reimbursement is a question of interest, however, we have no experience data with which to suggest an answer. The relative cost effectiveness of either method would, we believe, be influenced by the volume and frequency of services provided by the respective practitioner as well as by the range of other health care services such a practitioner is competent and legally authorized to provide. In organized settings, a psychiatric nurse specialist could be a salaried employee or could negotiate a contract with the setting for payment on a fee for service basis. It seems there are advantages to both methods for the setting as well as for the practitioner and that either could be most cost effective for that setting.

We appreciate the opportunity to respond to these questions. Please contact me for additional information as needed.

Sincerely,

PATRICIA A. JONES,
*Director, Center for Governmental Affairs,*
*(Washington Office).*

Chairman JACOBS. Ms. Peters.

## STATEMENT OF MARY E. PETERS, M.S., OTR, GOVERNMENT SPECIALISTS, GOVERNMENT AND LEGAL AFFAIRS DIVISION, AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.

Ms. PETERS. I am Mary E. Peters and I am on the staff of the Government and Legal Affairs Division of the American Occupational Therapy Association.

Prior to my working with the association, I have been employed as a psychiatric occupational therapist in a number of mental health settings. Our comments concerning H.R. 6092 are included in our written testimony as well as a thorough description of occupational therapy services in psychiatric settings.

However, in the interests of time I will be as brief as possible.

The association represents over 35,000 members. Nearly 45 percent of our therapists are employed in the field of mental health and many of them in community mental health settings.

In general, occupational therapists value the impact and importance of productive activity in the maintenance of health, prevention of disability, and the rehabilitation of mentally ill.

They believe that a significant number of individuals with emotional disability can remain independent and productive in the community with access to a range of mental health and support services.

Occupational therapists are in a unique position to provide these services because of their strong professional equipment to bring the patient to an optimal level to function within our society. We are concerned with all of the factors which affect the health of individuals and impact their inner actions with their family, the workplace, and the community.

At the present time, reimbursement for psychiatric occupational therapists is available on an inpatient basis for beneficiaries of medicare and medicaid. If occupational therapy were included as a mental health specialty in this bill, low income and elderly individuals could obtain these services in less costly outpatient settings.

The American Occupational Therapy Association strongly supports the concepts of H.R. 6092 that would expand reimbursement for medicare and medicaid beneficiaries for outpatient services provided by clinical psychologists, clinical social workers, and certain psychiatric nurse practitioners.

We urge the subcommittee to include occupational therapy in H.R. 6092 to insure that the elderly and low-income individuals will be eligible to receive our services in outpatient settings which are accessible and cost effective.

I am including in my testimony language defining an occupational therapist as a mental health specialist.

In summary, Mr. Chairman, the association strongly supports H.R. 6092 and is very supportive of programs to increase the accessibility of needed mental health services to medicare and medicaid beneficiaries.

The addition of these services, including occupational therapy, is clearly needed and has the potential to reduce dependence on very expensive continued institutionalization.

The issue is not whether the elderly and the poor should receive mental health services but in which setting treatment should be provided in order to be the most cost effective.

Mr. Chairman, we offer our assistance to the committee in improving the quality of mental health care services.

Thank you.

Chairman JACOBS. Thank you very much.

[The prepared statement follows:]

## STATEMENT OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

The American Occupational Therapy Association, Inc. (AOTA) is pleased to submit comments on H.R. 6092, the proposal to amend the supplementary medical insurance part of the Medicare program, and the Medicaid program to provide direct reimbursement for clinical psychologists, clinical social workers and psychiatric nurse practitioners. The Association was formed in 1917 and represents over 35,000 members. Nearly 45 percent of our practicing therapists are employed in the field of mental health, many of them in community mental health settings. Mental health issues are of equal importance and concern to therapists providing services to the physically and developmentally disabled.

Our brief comments concerning H.R. 6092 are divided into three categories: (1) a description of occupational therapy services in mental health settings, (2) present reimbursement for occupational therapy services under Medicare and Medicaid in mental health settings, and (3) a recommendation for the inclusion of occupational therapy in H.R. 6092.

### OCCUPATIONAL THERAPY PRACTICE IN MENTAL HEALTH

Occupational therapy is the application of goal-oriented, purposeful activity in the assessment and treatment of individuals with psychological, physical or developmental disabilities. These services address the development and maintenance of adaptive skills and performance capacities which enable the patient to achieve optimal levels of function in such activities of daily living as work and self-care skills. The occupational therapist's functional assessments and treatment-rehabilitation methods are concerned with specific performance components which include: motor, sensory integrative, perceptual-cognitive, psychological, and social-interpersonal functions, as well as those environmental factors that inhibit performance.

Occupational therapists value the impact and importance of productive activity in the maintenance of health, the prevention of disability and the rehabilitation of mentally ill. They believe that a significant number of individuals with emotional disability can remain independent and productive in the community with suitable access to a versatile range of mental health and support services. Occupational therapists are in a unique position to provide these needed services because of their strong professional commitment to bring the patient to an optimal level of function within our society. Occupational therapy is concerned with all the factors which affect the health of individuals and impact upon their interactions within the family, the work place, and the community at large.

Occupational therapy serves in the context of goal-directed use of time, energy, interest and attention to foster adaptation and productivity, to minimize pathology and to promote the maintenance of health. Assessment and treatment services may include: Independent living skills such as self-care and self-maintenance; task oriented treatment using creative-expressive modalities, education, and other role related activities; pre-vocational and work adjustment programs (employment and academic preparation, homemaking, child care/parenting); sensory-motor, including neuromuscular and sensory integrative asssessment and treatment; therapeutic exercise to enhance functional performance; discharge planning and community reentry; and patient/family education and counseling.

Upon referral, or as members of an on-going multidisciplinary team, occupational therapists participate in identifying problems, establishing overall treatment objectives, and developing treatment and discharge plans. In all instances, specific activities and techniques are selected and based upon a functional evaluation of the patient and the resources of the discipline (purposeful activity). Occupational therapists work in a broad range of practice areas and settings. Within the scope of general pyschiatry, services are provided to children, adolescents, adults, and the elderly of all functional levels and diagnostic categories, in institutional, community-based, partial hospitalization, residential treatment and forensic programs. These programs are offered in general and pyschiatric hospitals, nursing homes, psycosocial and physical rehabilitation centers, sheltered workshops, clinics, public and private schools, group homes, correctional institutions, home health agencies, community mental health centers, day care centers, private practice, physicians' offices, as well as industry and business.

## PRESENT REIMBURSEMENT FOR OCCUPATIONAL THERAPY SERVICES UNDER MEDICARE AND MEDICAID

Reimbursement for occupational therapy services is provided as an inpatient and outpatient service under many federal programs. Medicare and Medicaid provide the largest amount of federal third party reimbursement for this service. Other federal legislation which authorizes support for occupational therapy includes: The Rehabilitation Act of 1973; the Maternal and Child Health and Crippled Children Block Grant; the Older Americans Act; the National Arthritis Act of 1974; the Civilian Health and Medical Programs for Uniformed Services Act (CHAMPUS), and the Community Mental Health Centers Act.

Occupational therapy is included within many of the options offered under the Federal Employees Health Benefit Program (FEHBP).

Among major insurance companies offering plans which include occupational therapy are Blue Cross, Traveler's, Prudential, Continential Casualty and Aetna.

At the present time, reimbursement for psychiatric occupational therapy services is available only on an inpatient basis for beneficiaries of Medicare and Medicaid. If occupational therapy were included as a mental health specialty in H.R. 6092, low income and elderly individuals could obtain these services in less costly outpatient settings.

## INCLUSION OF OCCUPATIONAL THERAPY IN H.R. 6092

Evaluation and training in self-care skills is an intergal part of all mental health programs for any setting, disability, or age group. In a mental health care setting, occupational therapy programs emphasize the need for independence and self reliance in dealing with the environment and the restoration of physical and mental functioning. In the treatment of populations such as the elderly and the chronically mentally ill, impairment in the skills and behaviors needed to exist in the community are common. When we consider the current deinstitutionalization policies in the field of mental health and that a large portion of the costs of Medicare are aimed at providing care for the institutionalized elderly, it is clear that programs to preserve the independence of this fragile population can be of considerable benefit in reducing hospitalization and custodial care costs.

The American Occupational Therapy Association, Inc. strongly supports the concepts of H.R. 6092 that would expand reimbursement to Medicare and Medicaid beneficiaries for outpatient services provided by clinical psychologists, clinical social workers, and psychiatric nurse practitioners.

We urge the subcommittee to include occupational therapy in H.R. 6092 to ensure that the elderly and low income individuals will be eligible to receive our services in outpatient settings which are accessible and cost-effective. I am including in my testimony language defining an occupational therapist as a mental health specialist. We recommend that this addition be made to H.R. 6092 as follows:

Section (bb) 1, p. 2, add; "or an occupational therapist (as defined in paragraph 6)."

Paragraph (6) new section for p. 3:

"(6) The term 'occupational therapist' means an individual who—

"(A) is currently certified as an occupational therapist, registered (OTR) by a duly recognized national professional occupational therapy organization; and

"(B) possesses a doctoral or master's degree in occupational therapy or a mental health related field from an accredited educational institution; or

"(C) has five years of experience as an occupational therapist in a mental health setting; and

"(D) in states where licensing is required, is licensed as an occupational therapist."

The American Occupational Therapy Association, Inc. strongly supports H.R. 6092 and is very supportive of programs to increase the accessibility of needed mental health services to Medicare and Medicaid beneficiaries. The addition of such services—including occupational therapy—is clearly needed and has the potential to reduce dependence on very expensive continued institutionalization. The issue is not whether the elderly and the poor should receive such mental health services, but in which setting such services should be provided in order to be the most cost-effective.

The AOTA welcomes the opportunity to present these views and offers its assistance to the Committee in improving the quality of mental health care services.

Chairman JACOBS. Dr. Bowman.

## STATEMENT OF JOHN BOWMAN, M.D., PRESIDENT, INDIANA PSYCHIATRIC SOCIETY, AMERICAN PSYCHIATRIC ASSOCIATION

Dr. BOWMAN. Thank you, Mr. Chairman.

I am Dr. John Bowman, a psychiatrist from Kokomo, Ind., and president of the Indiana Psychiatric Society and member of the American Psychiatric Association representing 27,000 members.

In behalf of the APA we appreciate the opportunity to testify today. I have about 20 pages of written documents and a research bibliography, and I would ask that you include them in the record of the hearing.

I will simply abstract from it and go for the 50 cents.

Chairman JACOBS. You are one psychiatrist that is a good psychologist.

Dr. BOWMAN. I am just a Hoosier doctor who specialized in psychiatry.

I am in the trenches with the people being served under medicare. I would like to share with you some highlights from the paper I mentioned explaining why the APA would be opposed to H.R. 6092 as currently written.

There are appropriate roles which psychologists, social workers, and psychiatric nurses can play in responding to the treatment needs of the mentally ill elderly under medicare provided that there has been a suitable medical evaluation, including a differential diagnosis, and comprehensive treatment planning.

The elderly suffer both primary and secondary mental disorders. Primary are those disorders such as paranoia, schizophrenia, depressions. These disorders are frequently treated more successfully by psychopharmocology than by psychotherapy.

I think it is a point that has not been mentioned even one time so far today. But it is extremely valid and this subcommittee needs to know about that.

Second, mental disorders in the elderly may be secondary to the complex medical-physical problems that they have: Degenerative illnesses, neoplastic illnesses, circulatory, and so on. To try to treat psychotherapeutically an elderly person without an awareness as to the nature of these diseases would be deficient and would not be good care for the elderly.

So, we are proposing that the elderly deserve a good medical evaluation, complete differential diagnosis, and then appropriate treatment planning.

This is the type of process that is under a physician's direction, frequently, but not always, a psychiatric physician.

The bill referred to four core professions as mental health specialists. The use of the term "mental health specialist" itself obviates something. Psychiatrists are physicians who spend 4 years in specialized training in the diagnosis and treatment of mental illness and are deeply concerned that the proposed inclusion of psychiatrists in a new legislative category is totally unnecessary and inappropriate.

Psychiatrists are physicians who specialize in diagnosis and treatment of mental illness and, thus, are first and foremost physicians, and accordingly are well covered by other legislative provisions of the Social Security Act as are all other physicians who diagnose and treat illness.

The APA looks forward to working with you in the coming Congress on this bill.

Thank you.

[The prepared statement follows:]

## STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Mr. Chairman and Members of the Subcommittee, my name is John Bowman, M.D. I am President of the Indiana Psychiatric Society and a member of the American Psychiatric Association, a medical specialty society representing over 27,000 psychiatrist nationwide. I serve as a staff psychiatrist at and am the former medical director of the Regional Mental Health Center in Kokomo, Indiana, and am an assistant clinical professor of psychiatry at the Medical School of Indiana University. I have also served as a teaching consultant to the Veterans' Administration Hospital in Marion.

The APA appreciates the opportunity to share with you our views on legislation to amend the Medicare program to provide reimbursement to "Mental Health Specialists," H.R. 6092 introduced by Congressman Floyd Fithian.

Since 1979, the APA has testified before this subcommittee each year and pointed out that as our current laws are drafted, as many private insurance plans are drawn, and as national or catastrophic or, today "competition" health insurance programs have been developed, mental illness inappropriately has been considered grossly different from physical illness—not treatable, not reversible and not equally reimbursable when treatment is provided.

We would like to believe that the subcommittee's decision to hod this hearing was based upon its recognition that—as the APA has testified—nervous, mental and emotional disorders are diagnosable, such illness are treatable, and the cost are indeed cost-effective when reimbursement is available.

It has been and remains a tragic commentary that not one of the Federal Health Insurance proposals which has come before this or any other Committee of Congress recognizes the need to assure that, consistent with the report of the President's Commission on Mental Health, individuals may "have their suffering alleviated insofar as possible." The mentally ill may have their suffering alleviated up to a severely limited dollar amount, or a specific number of limited visits, and after such limited dollars or limited number of days is past, they may suffer not only from their mental disorder, but from the spectre of uninsured health care costs as well.

We are speaking of six million older Americans today covered under our Medicare program, the President's Commission on Mental Health stated: "The prevalence of mental illness and emotional distress is higher among those over age sixty-five than in the general population. Up to 25 percent of older persons have been estimated to have significant mental health problems". Even more tragic is the Commission's statement that "senility is a term loosely applied to thousands of older Americans, yet as many as 20 to 30 percent of those so labeled have specific conditions that can be diagnosed, treated and often reversed."

Indeed, a recent Washington, Post article noted that as many as 15 percent of those persons diagnosed with disorders such as dementia (including Alzheimer's disease) actually are suffering from reversible psychiatric depression.

Countless millions of inpatient health care dollars, long term skilled nursing care dollars, are inappropriately spent on individuals who may be suffering from reversible mental illness. The American Hospital Association's Special Committee on Federal Funding of Mental Health Services, in a recently published report has stated: "By limiting psychiatric treatment as an essential element of care, the system forces the shift of patients to other specialties of health care. This is neither cost-effective nor conducive to the delivery of high-quality care." The Special Committee recommended that: "mental health services be funded at parity with other health services and that discriminatory exclusions be eliminated."

The American Medical Association stated that it had: "formally examined the issue of discrimination in the conferring of health benefits by third party payors in 1975. At that time, the AMA's House of Delegates urged, in reference to government programs, that 'benefits be provided covering emotional and mental illness equivalent in scope and duration to those benefits provided for other medical or physical illnesses.' This position was restated in 1978 with reference to both governmental and private insurance programs." The AHA Special Committee further noted that: "Numerous studies provide evidence of a direct relationship between mental and physical health. A significant number of these studies has also demonstrated that the provision of mental health services reduces the total cost of health care."

This subcommittee is aware of these and other cost-effectiveness studies presented to it over the past years by the APA and other organizations, and rather than present them at this time, I call your attention to the appendix to this statement which contains extracts of the studies and A bibliography, and ask that it be included as part of my printed testimony.

The bill under consideration today raises interesting dilemmas, which I would like to address briefly before responding specifically on the subject of reimbursement to "mental health specialists."

First, does the Committee simply seek to expand the personnel base under which limited reimbursement is now available, or rather to begin to recognize mental illness for what it can be: A profoundly incapacitation and personally painful and disturbing illness comparable, in severe cases, to the worst pain experienced by those who are suffering from a physical illness which should be reimbursed on equal footing with other illnesses?

Second, at what point does "health care" as provided under title XVIII of the Social Security Act end and title XX social services begin? The ANA's Special Committee, mentioned earlier in this testimony, raised this matter and suggested that: "Public policy debate over the right to and the nature of health services might usefully focus on a set of services deemed to be essential. Such debate should strive to define the irreducible essential care to which each citizen is entitled." They recommended the "establishment of a national health policy that would define essential physical and mental health services for publicly funded programs."

Third, and corollary to the second point, should medicare be paying for the treatment of illness per se or broadening that base to provide reimbursement for help with "problems of living," "achievement of potential" or other portions of the health/happiness/social welfare continuum?

Fourth, what role, if any, should community mental health centers have in the provision of care to the medicare population?

With these over-arching public policy questions in mind, I would like to turn more specifically to the issue of the reimbursement of "mental health specialists" under medicare as articulated in H.R. 6092, in terms of the need for such expansion of mental health services under medicare, the appropriate role for psychiatrists, the role or roles which nonphysician mental health practitioners can play, quality and scope of care, and cost.

The APA recognizes that the enormity of the needs for psychiatric care among the elderly population stands out in stark contrast to the limited resources (in terms of both manpower and money) available to satisfy those needs. With respect to psychiatric manpower, we are very much aware of the shortage of this medical specialty, a shortage documented by Congress in its concern about continued NIMH clinical training resources, by the report of the GMENAC, and by studies by private organizations such as the Rand Corp. Funds for psychiatric care of the elderly, already restricted, are likely to grow even more scarce, further tilting the balance between demands and services. At the same time, specific psychiatric care requirements of this special population have been poorly defined and delineated, so that psychiatrists ofter have been called upon to remedy many of the elderly's problems that have been beyond the scope both of their expertise and their means. Based upon the foregoing, several critical questions present themselves: Realizing that Psychiatrists are too few in number to assume full responsibility for care of all psychiatric disorders in the elderly, what services provided specifically by psychiatrists are most needed? What specific role should psychiatrists play in the care of elderly patients with these disorders? What specific caretaking roles are psychiatrists, and psychiatrists alone, qualified to fill?

To respond to those questions, it is necessary to define as exactly as possible the meaning of the term "psychiatric services;" Then to set forth the specific medical conditions for which these services should be provided; and finally to provide an explication of the nature of these services and the extent to which these services should be make available.

## PSYCHIATRIC SERVICES

There has been a clearly perceived danger that the general public and even some psychiatrists might define "psychiatric services" to include any and all measures that might either augment satisfaction or diminish discontent in elderly persons. Moreover, physicians and the public in general might assume uncritically that "psychiatric services," even if narrowly defined, should be prescribed as a nostrum for all sorts of distress (whatever their nature and genesis) which may be experienced by elderly persons.

Sadly, much of the discomfort, discontent, and unhappiness that afflicts many of the elderly is unavoidable and sometimes, even appropriate, in the sense of being in keeping with their personal and environmental circumstances. Much of it may be interpreted even as evidence of robust psychological health. The distress that emanates from multiple losses, chronic physical disease, and an awareness of approaching death cannot be abolished by the provision of "psychiatric services," nor can the discomfort that results from inadequate housing, poor nutrition, limited recreational opportunities, and a dilapidated or dangerous neighborhood. Similarly, loneliness, isolation, and boredom do not in themselves lead directly to a need for psychiatric services. Although the needs of the elderly are many, and although these needs certainly may contribute to psychiatric disability, these needs can be described most accurately in terms of human needs deserving of human responses or of social needs deserving social responses, not in terms of medical needs requiring psychiatric treatment. However valuable these and other responses and services may be, and however deserving they may be of support by psychiatrists as concerned members of the community, they should not be mistaken for or confused with psychiatric services provided for the treatment of mental illness. Indeed, the elderly should properly be affronted by the suggestion that these other nonmedical supportive services be equated to nonsubstitutable medical treatment.

A "psychiatric service" should derive from those specific skills in the diagnosis and treatment of mental disorders that are learned in the course of psychiatric training and practice. Psychiatric services should then be defined in terms of specific psychiatric measures taken in response to defined psychiatric disorders. Thus, even though psychiatric disorders may be more common in old age than in youth, the vast majority of the elderly do not suffer from psychiatric illness, nor do they require psychiatric treatment. This perspective does not in any way deny the possibility that a variety of social and environmental interventions may through prevention lessen the incidence of psychiatric disorders in the elderly. It does, however, suggest that such interventions should not be labeled psychiatric treatment or should their costs be labeled as medical costs. For example, sanitary services are not generally accounted as medical costs, even though they certainly lessen the incidence of many infectious diseases. The Older Americans Act congregate meals program certainly helps assure adequate nutrition among those elderly who participate, but is not considered a medical cost though it helps avoid some of the medical sequelae of poor nutrition.

## ROLE OF PSYCHIATRIST

From this vantage point, it becomes important to identify those services that should be provided, specifically and, sometimes uniquely by psychiatrists for elderly patients who suffer from mental disorders.

The psychiatrist's role clearly cannot be understood apart from the situations and circumstances in which it is played. There is a strong case to be made for the proposition that psychiatrists should be involved in the diagnostic appraisal and treatment planning of every elderly person suffering from the major categories of psychiatric disorder which are among the most severe and most frequent of old age: dementia, depression (affective disorders), schizophrenia, paranoid disorders, anxiety, adjustment disorders, and the psychiatric complications of physical illness. If quality medical care is accepted as a valid goal for the Medicare program and all other Federal, public and private health insurance programs, then there are compelling reasons to argue that psychiatrists who are well versed in the mental disorders of old age should participate, with varying degrees of involvement, in the care of every elderly person with severe psychiatric dysfunction. For the most part, only psychiatrists, who have been so trained possess both the knowledge base and the combination of medical skills required to deal with the multifaceted medical (and their associated psychological and social) problems encountered by these patients and their families.

The psychiatrist is not only trained to do psychotherapy. He or she is also trained to make differential diagnoses, to prescribe medication and, if need be, to hospitalize a patient for treatment.

For a number of reasons, the extent of psychiatric involvement will vary enormously from situation to situation. There are not, now, nor in the foreseeable future will there be, enough psychiatrists to accept full responsibility for the care of all elderly suffering from psychiatric disorders. Moreover, in many of these patients, medical problems overshadow the psychiatric problems, so that other physicians more properly assume primary responsibility for the patient's care. However, at least psychiatric consultation for diagnosis, treatment planning an evaluation should be routinely available. Many treatment measures can be administered effectively by non-psychiatrist physicians and by other health professionals and do not require the specialized services of the psychiatrist. Nonetheless, because of the complex interrelationships between physical and psychiatric medical problems in the elderly, the differential diagnosis and the comprehensive planning for treating psychiatric dysfunction in this group requires psychiatric input if care of acceptable quality is to be achieved.

Congress recognized the special role of psychiatrists in the diagnosis and treatment planning of the Medicare population in both the Mental Health Systems Act and the Older Americans Act Amendments of 1981 when in establishing in the former a special priority program for the elderly and in the latter a demonstration program (or programs) to provide treatment to the elderly who may be diagnosed as mentally ill, both required the provision of a medical differential diagnosis.

What Congress recognized in adopting this legislation is the critical interplay—particularly in the elderly population—of physicial and mental pathology. For example, without a clear medical diagnosis, a patient might be treated by a non-physician for an acute anxiety state when the root cause may well be a thyroid condition which often is manifested in classical symptoms of anxiety. Similarly, only through a medical differential diagnosis and treatment planning can a patient be assured against unnecessary provision of mental health services for what actually may be medically determined to be a manifestation of drug-drug interaction. As the Subcommittee is aware, the elderly are among the most intensive users of a wide variety of pharmacologic agents, but under physician supervision. Many of the illnesses of the elderly can be treated or reversed if and only if they are accurately and promptly diagnosed. Indeed there are over 100 reversible psychiatric syndromes[1] that mimic senile dementia which may need to be considered through a differential diagnosis before either final diagnosis of the patient as demented or beginning treatment, whether by psychopharmacologic agents, psychotherapy or some combination thereof, when determined to be medically appropriate.

Further, in the course of a differential diagnosis and treatment plan prepared by a physician, it may be determined that the patient indeed is suffering from a nervous, mental or emotional problem, corollary to, the result of or wholly independent of a physicial disorder. The decision, and a medical decision, would then be how to best treat any co-existent physical and emotional problem. We do not intend to suggest that only a psychiatrist should provide the treatment for either the identified physical or mental problem. However, we do believe the medical information that such problems exist is critical in the planning and ultimate conduct of the treatment.

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[1] Butler, Robert N. "The Need for Geriatric Medicine." Background paper prepared for President's Commission on Mental Health 1977.

I mentioned earlier the role of the psychiatrist as a licensed physician who is authorized to prescribe medications. The Subcommittee should not underestimate the particular value medication has for the treatment of mental illness. It has been found, for example that both depression and manic psychoses are among the most destructive and prevalent types of mental illness in the nation. As many as 4.5–7.5 million individuals are estimated to suffer from depression alone, working severe hardship upon the patient and their families in terms of economic impact and, indeed, mortality. It has been found that antidepressants are highly effective in treating the severely depressed—benefitting around 80 percent of the acutely depressed, by relieving symptomology and delaying or preventing relapse.

Lithium as a treatment for manic depression, over the past decade, has been estimated to have saved $2.88 billion in direct mental health costs over the past decade, and has further saved $1.28 billion in lost productivity among those treated in that time span.

The Subcommittee should not adopt the simplistic and incorrect premise that psychiatric treatment is tantamount to psychotherapy. Psychotherapy—A treatment methodology practiced by psychiatrists and non-physician mental health personnel alike—is neither the only treatment which can be rendered nor the appropriate treatment for all patients. In many instances, appropriate medication, coupled with brief psychotherapy, may be more appropriate. In some severe cases, hospitalization and a combination of treatment modalities in the inpatient setting, may be more appropriate. Non-physicians have neither the skills nor training to prescribe psychopharmacologic agents or admit patients to hospitals.

Throughout my testimony, I have made reference to appropriateness of care, and particulary the quality of care—with attention to the clear delineation through diagnosis of physical versus mental illness. I would like to turn now to other issues.

### COST OF CARE

While CHAMPUS may provide reimbursement to each of the four core mental health professions as defined by NIMH, other Federal Health Insurance Programs (excluding, of course Medicare) do not, nor do the majority of health plans offered by major corporations in the country. Further, if one closely assesses the data of the CHAMPUS experience itself, it lays to rest a significant myth that psychiatrists are the most costly among those practicing psychotherapy, Indeed a very recent report prepared by CHAMPUS stated: "The average amount paid per outpatient visit for psychiatrists was $51 and for psychologists the amount was $57. Therapists (EG : Social Workers, Psychiatric Nurses) receive an average of $43 per visit. For inpatient visits, the average amount paid per visit ranged from $30–$50, with psychologists at the top end of the range."

Clearly, the economic arguments in support of this legislation are not borne out in practice as evidenced by the CHAMPUS data. Moreover, as we have stated in testimony before this Subcommittee, the concept of "competition" in the health care marketplace is based on a false assumption: The assumption that the health care dollar fluctuates based on a normal model of supply and demand. Individuals faced with illness and survival are not going to "shop" as they might for other commodities. The gap in information between consumer and provider is a fact respecting the health care decision process and one in which the physician has knowledge and expertise not immediately available to the consumer without the requisite minimum of eight years of medical education and training. Moreover, not only is the consumer not fully informed, but what is demanded is information itself. Consequently, fully informed consumer choice is at best limited due to the complexity of disease and the diagnostic process itself and the nature of the health care transaction as an information-seeking process. Hence, consumer sovereignty in this situation is severely impaired, and raises questions as to how fully informed the health care consumer can really be.

Moreover, there is no reason to accept the proposition that costs will be reduced since, we understand, that in some states once a non-physician mental health professional is licensed, there is a strong effort made to assure that the minimum Medicaid and other state-controlled fee structures are brought to a level comparable to that provided to psychiatrists and other physicians.

The current apparent disparity in cost cited in the Congressman's introductory remarks may well be based on the simple fact that many non-physician mental health practitioners are working in organized care settings where they are salaried rather than paid on a fee-for-service basis. Since salary is based in large measure upon qualifications (such as nature and extent of professional education, type of degree, as well as nature of assigned responsibilities), it is understandable that the rates would be directly proportional to the levels of these factors. I would be remiss if I did not also point out that in such organized care settings, non-physician mental health practitioners are customarily under medical management.

Before I close, I would like to raise one further point: the use of the term "mental health specialist" itself. Psychiatrists are physicians who have spent four years post-medical school in specialized training in the diagnosis and treatment of mental illness. We are deeply concerned that the proposed inclusion of psychiatrists in a new legislative category called "mental health specialists" is totally unnecessary and inappropriate. Psychiatrists are physicians who specialize in the diagnosis and treatment of mental illness and thus are first and foremost physicians, and accordingly are well covered by other legislative provisions of the Social Security Act as are all other physicians who diagnose and treat illness.

Mr. Chairman, the APA believes that there are appropriate roles which psychologists, social workers and psychiatric nurses and others can play in responding to the treatment needs of the mentally ill elderly under Medicare, provided that there has been a suitable medical evaluation, including differential diagnosis and comprehensive treatment planning. We look forward to working with the subcommittee in the coming Congress to achieve our mutual goals.

[Appendix]

## THE CASE OF EQUITABLE PSYCHIATRIC BENEFITS IN HEALTH INSURANCE

The human and economic costs associated with untreated mental illness have been well established. As early as 1974, the National Institute of Mental Health estimated that the indirect costs of mental illness were close to $20 billion. The study noted that "Indirect costs are the income or income-equivalent losses which result from deaths due to mental illness, total disability due to mental illness and the loss of productive time to those individuals. . . ."[1] Moreover, such costs do not reflect "all losses associated with partial disabilities, with pain and suffering not fully reflected by lost earnings, with homicides in the population not treated for mental illness and with the excess death incidence among those who have a history of mental illness but received no care."[2] Indeed, NIMH noted that the cost might well have doubled to $40 billion, in one year alone, if such above-mentioned factors had been included.

The American Psychiatric Association argues that the cost-benefit and medical effectiveness of psychiatric services for patients with mental disorders in the general health sector are demonstrated in a substantial body of research[3] and show that notwithstanding other arguments to the contrary, psychiatric benefits are insurable; that they save other health care costs; and that they help make up the lost dollars of productivity.

Among those studies are the following:

Blue Cross of Western Pennsylvania studied the medical/surgical services utilization of a group of subscribers to whom mental health services were made available and that of a comparable group to whom they were not. The findings showed a significant reduction in the medical/surgical utilization for the group with psychiatric benefits as compared to the group without these benefits. The monthly cost per patient for all medical services was more than halved—dropping from $16.47 to $7.06. This cost savings substantially exceeded the costs of providing the psychiatric care.[4]

A longitudinal study carried out in a single Texas county from 1973 to 1977 showed that access to treatment for mental illness in inpatients over age 65 resulted in a reduction in mean length of stay from 111 days to 53 days and a cost savings of more than $1.1 million.[5]

A Kaiser Permanente study compared two matched groups of 152 patients each, one of whom received psychiatric intervention (study group) and one of whom did not (control group). Both groups initially were similar in their rates of general health care services utilization. Over a five-year period, the control group showed esentially no change in general health care utilization while, in sharp contrast, the study group experienced a reduction in its non-psychiatric outpatient visits by 62 percent, and in its inpatient days by 68 percent.[6, 7]

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[1] National Institute of Mental Health, 1976. Statistical Note No. 125. Division of Biometry and Epidemiology. Department of Health and Human Services.

[2] Ibid.

[3] Jones, K.R. and Vischi, T.R. Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization: A Review of the Research Literature. Supplement to Medical Care: 17. December 1979.

[4] Jameson, J., Schuman L.J., and Young W.W. The Effects of Outpatient Psychiatic Utilization on the Costs of Providing Third-Party Coverage. Blue Cross of Western Pennslvania, Research Series 18, December, 1976. Also in: Medical Care, 16 383, 1978.

[5] Texas Research Institute of Mental Sciences, Geriatric Services. Houston, Texas. December, 1977. (Departmental Memorandum.)

The Group Health Association of Washington reported that patients treated by mental health providers reduced non-psychiatric physician usage within the HMO by 30.7 percent in the year after referral for mental health care was made available, compared to the previous year. In addition, there was a 29 percent decrease in laboratory and x-ray services.[8]

The Kennecott Corporation found that in a study of 150 men who received needed psychotherapeutic services, there was an estimated 6-to-1 benefit-to-cost ratio as a result of the program, and recorded a 52 percent attendance improvement and a 74.6 percent decrease in medical-surgical utilization costs after the psychotherapeutic services.[9]

In a West German study involving more than 1,000 patients with primarily chronic symptoms, it was found that in the five years following the availability of psychiatric services, the average annual number of hospital days per patient declined from an estimated 5.3 days to 0.8 days.[10]

A recently completed study compared over the period of a year the post-operative course of a group of 24 elderly patients who had undergone surgery for repair of hip fractures and who had available liaison psychiatric services with a similar group of 26 patients who had the same kind of surgery but did not receive the liaison services. The group receiving psychiatric liaison care required an average of 12 days less hospitalization (30 versus 42 days—a 28.6 percent reduction), resulting in estimated savings of $193,000 over the course of one year (the psychiatric liaison services cost $10,000 for the same year). Moreover, twice as many patients who had psychiatric liaison services were able to return home (rather than to nursing homes or other less cost-effective institutional settings.)[11]

The introduction of lithium as a medically indicated psychiatric treatment of manic depression, now often used in lieu of more costly hospitalization, alone, has accounted over the past ten years for a $2.88 billion savings in direct mental health costs and an additional $1.28 billion in productivity. Figures were arrived at by comparing the costs of lithium treatment to the cost of the usual (and generally less effective) treatment of former years.[12]

These "offset" studies, demonstrating the savings which can be attributed to timely, appropriate psychiatric intervention, whether in organized care setting, in inpatient facilities, whether through the use of psychopharmacologic advances or more traditional "talking" therapy, point to the building body of literature articulating the benefit of appropriate psychiatric treatment.

## [Subsequent to the hearing, Mr. Gradison submitted the following questions:]

*Question 1.* Some critics argue that unhappiness, anger, depression and stress are a normal part of life and not necessarily signs of mental illness or instability. They also argue that many of these are normal self limiting that is, they are just problems of life and living that disappear in time. Would you agree with that assessment?

Response. Certainly the experiences of unhappiness, anger, "depression," and stress can be normal and unavoidable elements of daily living at some time or another for most persons in a complex society and without other pathology would not necessarily be, as phrased by the first question, "signs of mental illness or instabil-

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[6] Follette, W. T. and Cummings, N. A. Psychiatric Services and Medical Utilization in a Prepared Health Plan Setting. Medical Care, 5: 25, 1967.

[7] Cummings, N. A. and Follette, W. T. Brief Psychotherapy and Medical Utilization. In: "The Professional Psychologist Today: New Developments in Law, Health Insurance and Health Practice." H. Dorkin, Ed. San Francisco, Jossey-Bass Publishing, 1976.

[8] American Psychiatric Association. Testimony on Health Maintenance Organizations, presented before the Committee on Labor and Human Resources, U.S. Senate, April 22, 1981.

[9] Washington Business Group on Health. Testimony on Federal Employee Health Benefits, presented before the Subcommittee on Compensation, U.S. House of Representatives, June 4, 1981.

[10] Duehrssen, A Katamnestiche ergebnisse bei 1004 patienten nacht analytischer pyschotherapie. Zschr. Psychosom. Med., 8: No. 2, 1962.

[11] Levitan, S. J. and Kornfeld, D. S. A study of Liaison Psychiatry Effectiveness: Clinical and Cost Benefits. "Am. J. Psychiatry," 138:790–793, June, 1981.

[12] Reifman, A. and Wyatt, R. J. Lithium: A Break in the Rising Cost of Mental Illness. "Archives of General Psychiatry," 37:385–388, April, 1980.

ity". When as such, these experiences are usually dealt with adaptively, particularly by persons with basically good psychological health; they are therefore self-limiting. The qualifying consideration pertains to those circumstances in which the degree and duration of the experience cited in the question clearly exceeds the capacity of the individual to cope effectively (either because of the intensity and sustained nature of the emotional problem and/or underlying psychological vulnerability) and which results in objectively documentable disability with respect to meeting those responsibilities of ordinary life associated with the circumstances of the individual (work, school, family affairs, independent living, basic self-care, etc). Persons to whom this qualifying consideration applies, especially the elderly, require a psychiatric medical evaluation and diagnosis to sort out the frequent interplay or coexistence of physical and emotional health problems and to determine an appropriate treatment plan which addresses such problem comprehensively. It is well established—again particularly in the elderly—that slowly developing physical problems (e.g., cerebral arteriosclerosis) may initially be manifest as emotional and behavioral disorders, (e.g., severe depression) may closely mimic physical problems such as senile brain change.

*Question 2.* Under expanded fee-for-services reimbursement for outpatient mental health services would not there be more persons in the marketplace seeking out such patients to treat professionally rather than let time take care of the problem?

Response. If the criteria suggested in the answer the Question 1 are applicable (to wit: degree and duration of phrased experience(s) with objectively documentable disability), it is unlikely that the situation posed in Question 2 would occur. It is precisely the purpose of a medical-psychiatric evaluation to determine the nature of a patient's presenting problem(s), the degree of disability involved, the likelihood that the problem will resolve without further professional intervention within a resonable period of time, or, in the presence of clear disability of expected prolonged duration, what active treatment (frequently combining psychopharmacologic and psychotherapeutic methods) is indicated.

*Question 3.* To what extent can too much emphasis on mental health or mental illness and reliance on psychiatry and psychology create dependency rather than self-reliance?

Response. The goal of all psychiatric treatment (as in other fields of medicine) is to assist the patient to reacquire to the maximum extent possible that level of independence, self-reliance, and social competence from which he or she has been significantly reduced by disability arising from illness. Professional intervention is indicated only when comprehensive evaluation and diagnosis determine that, without such treatment intervention, an existing significant degree of impairment (see answer to Question 1) is unlikely to improve spontaneously or, on reasonable medical grounds, can be expected to worsen. In this sense, reliance on psychiatry is parallel to reliance on internal medicine and other medical specialties.

*Question 4.* How accurate are the diagnoses of mental illness and to what extent are people with physical difficulties being diagnosed erroneously as mentally ill?

Response. The reliability and accuracy of a medical diagnosis of mental illness is comparable to that of any other medical diagnosis for a physical illness. Criteria for diagnosis for mental illness have undergone progressive refinement over the past few decades, culminating in 1980 in publication by the American Psychiatric Association of the 3rd Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). This 3rd edition of the Manual, based on nearly a generation of clinical studies and research in the neurosciences, emphasizes clearly describable, objective findings in identifying clinical syndromes, requires assessment of any current physical disorder or condition that may bear on the understanding or management of the patient, includes an estimate of severity of psychosocial stressors that may have contributed to the onset or exacerbation of the patient's condition, and finally, requires an assessment of the degree of disability resulting from the patient's diagnosed condition in terms of the highest level of adaptation in the previous year. In practical use by psychiatrists, the DSM-III compares favorably in reliability and accuracy to diagnostic guides used in other medical specialities.

With respect to the second part of this question, it is true that a wide range of physical illnesses may initially present themselves as disturbances of behavior, emotion, or state of consciousness and may be misdiagnosed as some form of mental illness unless a comprehensive medical history and examination have been carried out. Much more frequently, the reverse situation obtains—i.e., serious mental disorder may be perceived by the patient and may initially manifest as an array of physical signs and symptoms, leading to misdiagnosis of the mental illness as a physical illness and resulting in inappropriate and costly treatment. An outstanding example of this type of misdiagnosis is the estimated 30 percent of elderly patients diagnosed as senile who in reality suffer from severe depression which is treatable and, in many cases, reversible.

Misdiagnosis in either direction—both of which can be personally tragic and economically costly for the patient—is more likely to be made when the initial evaluation fails to include adequately informed attention to the patient-as-a-whole, i.e., to both mental and physical aspects of health and illness and the subtle interaction between the two.

Chairman JACOBS. Thanks you very much.

Ms. Casber.

Ms. CASBER. I have a question for Dr. Bowman.

Dr. Carter has suggested that by limiting the medicare reimbursement to services offered by a psychiatrist, that we are limiting access of medicare beneficiaries to mental health services in areas where there is a psychiatrist available.

How would you respond to that?

Dr. BOWMAN. From my experience—and I see medicare recipients every day—there is no problem in people getting services. I work in a center where all these professions work together, so there is no barrier to service.

As currently written, there is no barrier to service.

Ms. CASBER. The question I am asking is what about those areas, for example, some rural areas, where there might not be a psychiatrist available?

Dr. BOWMAN. I cover Tipton, Ind., and Frankfurt, rural areas, there is no barrier to service.

Chairman JACOBS. Ms. Casber is talking about Kansas. Places like that.

Dr. BOWMAN. I cannot speak for that.

Chairman JACOBS. There are counties in Western States where it is not just an absence of a psychiatrist, Doctor, but absence of any kind of physicians and has been for decades.

The practitioners out there have been the sole source of medical care in such areas. That is what Ms. Casber is asking you to direct your attention to.

Would you make an exception in a case like that or have such a person do without until he can get to Kansas City or something?

Dr. BOWMAN. No, no, my assumption is that if they are in a rural area, there are family physicians around probably who can do much of the evaluation and if the family physician feels there is a need for psychiatric care, and the family physician wants to send them to a social worker or family psychologist, they can do it.

That is the way it is practiced today.

Chairman JACOBS. Thank you very much.

Thank you, each one of you, for your testimony. Particularly those who came in under the limit.

The final panel is the Washington Business Group on Health, Mr. Willis Goldbeck, president; American Mental Health Counselors Association, Dr. Richard Wilmarth, chairperson, Governmental Relations Committee.

I guess you are on deck first, Mr. Goldbeck.

## STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

Mr. GOLDBECK. I am Willis Goldbeck with the Washington Business Group on Health. Some of you know we are an organization for major employers, with an interest in health policy.

I might add that as a fellow purchaser with Congress, we buy much of the health care in the United States. We are here to support 6092 because it increases the appropriateness of care and we see a direct relationship between tax expenditures of our dollars and appropriateness of the care received.

It also will increase competition, and it fits the medicare needs of a great deal of the medicare population, a basically chronically ill population. A great deal of their mental health needs not medical in nature.

We support reimbursement for services appropriately provided by clinical psychologists and psychiatric social workers.

Our prior experience has nothing to say about the use of the nurse specialist, so we cannot make a contribution to that side of the argument.

What is not clear is the cost factor. It seems to me the array of studies on both sides leaves that question up in the air. The final decision on what is to be done cannot be made only on economic analysis. We do not base our support for H.R. 6092 on a straight economic analysis of its potential impact.

What we do understand is that this nation cannot afford to continue to ignore the mental health of any of its people, let alone the elderly, which use, for a variety of reasons, a disproportionate amount of services of all kinds of health care.

Medicare is not providing, is not spending enough on mental health right now. HCFA's own studies show it is spending less than 3 percent of medicare resources in mental health.

By any extrapolation of existing studies or analysis, less than 3 percent going to mental health is not in sinc with the amount of mental health care needs that any segment of the population has today.

We also know that medicare, and many poorly designed private plans pay vast amounts of money for false and inaccurate diagnosis that waste dollars on unnecessary medical care and institutionalization.

The current reimbursement programs are inherently discriminatory and other studies, including the Lewin study, which has not been mentioned, point out reductions in productivity by physicians, reductions in access to care, reduction in innovation by providers, resulting from these reimbursement restrictions.

In fact, the reimbursement patterns encourage the fruitless infighting among the mental health professionals which you heard testimony to today.

Private sector experience is particularly interesting because corporations, which certainly are not looking for extra things to spend money on today, are providing increases in mental health services and reimbursement for clinical psychologists and social workers through employee assistance programs at this time.

They are doing so because they find increasing efficacy from the standpoint of corporate measures such as reduced absenteeism, turnover, accidents, and reduced medical care utilization.

In many cases, in fact, these are add-on services. They are adding on appropriate mental health services not regularly provided for elsewhere.

The testimony that I provided includes examples by company of the efficacy of some of these programs and the way they are being conducted around the country.

I would like to conclude my remarks by noting three of the points made in other testimony.

It was suggested that, in fact, there was no serious competition impact by this legislation. That was the first speaker.

I would suggest the prior speaker clearly denies there is no competitive interest.

Indeed, it is perhaps not surprising, considering the APA also supported the FTC exemption of the professions which would be another detriment to advancement of medical care in the United States.

Quality assurance was raised as an argument early in the testimony today. It was stated that there would be a reduction in quality assurance. That argument would be moot if there were not competition for these services.

But the current system itself encourages poor quality by having that family physician who has never had any training in mental health whatever, be the primary referral agent and decisionmaker among the multiplicity of mental health service resources.

We would be much better off in many cases if the individual felt free, unstigmatized and able to receive care from the full range of mental health practitioners, who in turn, could be directly reimbursed.

It was also mentioned at the outset today that physicians referring to physicians equated with good communications.

All of you have sat through many hours of testimony in the past about medicare referral mills and absolute absence of any good communication through that system.

In fact, one could go so far as to say that referrals from those untrained are referrals based on ignorance and certainly not to be advocated as better than referrals amongst the mental health professionals themselves.

Let me conclude by making the point that we are, as a society, just beginning to come to grips with the degree to which the human mind has a capacity to have a significant relationship with a whole range of medical illnesses, illnesses thought to be only medical in the past.

We need to remove unnecessary barriers to the advancement of this kind of innovation, not support the continuation of unnecessary barriers through continuation of discrimination in reimbursement in medicare.

We support this legislation.

[The prepared statement follows:]

## STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

### EXECUTIVE SUMMARY

Our testimony supports H.R. 6092 which would make possible direct Medicare reimbursement for mental health services provided by clinical psychologists, clinical social workers, and psychiatric specialists.

Our position is based upon the following.

1. There is no quality of care justification for continuing the current reimbursement discrimination against these providers.
2. We believe the proposed change is consistent with the goal, which we share with the Administration and many in Congress, for greater competition in the medical care delivery system.
3. These providers increase the use of appropriate mental health services by the Medicare population.
4. The current Medicare policy is contrary to the trends in State and private sector systems for the payment and provision of mental health services.
5. In a well managed system, the possibility of cost savings is just as good as the possibility of cost increases . . . but the real justification for the change is that future expenditures would be more in line with the real needs of the covered population and those expenditures would be going to the actual provider rather than a middle "man" who is frequently not only useless but also, in the case of non-psychiatric physicians, unqualified.

### STATEMENT

My name is Willis B. Goldbeck, President of the Washington Business Group on Health. We are a health policy group for major employees who currently provide the medical benefits for more than 50,000,000 employees, retirees, and dependents.

From that number alone, you can feel confident that we share the committee's concern for the seemingly endless escalation of medical care costs.

I am here today to support H.R. 6092, a bill which would provide direct reimbursement under the Medicare program for mental health services provided by mental health specialists, specifically clinical psychologists, clinical social workers, and psychiatric nurse specialists (as well as psychiatrists).

There are at least three reasons for the Congress to adopt this change in Medicare reimbursement.

1. H.R. 6092 will result in more appropriate treatment.
2. H.R. 6092 is consistent with the public and private efforts to bring more competition to the medical care delivery system.
3. H.R. 6092 is consistent with the changes in the size of the Medicare population and the high level of emotional support needs this group has been shown to have.

You will note that I have not mentioned the cost issue. In my view, there is not the evidence, based on well designed studies, that would definitely establish either great cost savings or an explosion of costly and unnecessary utilization.

Studies conducted for the government and the experience of the private sector benefit plans are simply not conclusive. They suggest that mental health specialists who have previously billed their services through physicians—or have been forced to charge the patient—will increase their charges if they can bill an insurance carrier directly. However, there is no evidence that these increases are out-of-line with the services performed, or represent either fraud or abuse.

More importantly, there is mounting evidence that well designed mental health benefits with an appropriate mix of providers can deliver better services and cause a reduction in medical utilization. Not surprisingly, once they become independent providers, the specialists identified in H.R. 6092 are increasingly utilized. This, too, it seems to me, is appropriate. The goal of this bill is to encourage Medicare patients with the need for mental health services to use the most appropriate provider. It is desirable to have them increase their visits to clinical psychologists and social workers for the non-medical services professionals can provide.

Under the current system, the only winners are those medical practitioners who financially benefit from the referral-billing system. Since Medicare is supposed to serve the needs of patients, not providers, we believe our Medicare tax dollars will be better spent when the patient can get care directly from the most appropriate provider.

### *Mental health, the unavoidable price*

As a nation, we must leave behind our 19th century attitudes and accept the fact that we cannot hide from the real costs of mental illness, emotional disorders, and the stressors of our current society.

Currently, we pay—Medicare pays—a high price for underutilization and inappropriate utilization of the mental health benefit. Less than 3 percent of the Medicare budget goes for mental health services. By any reasonable estimation, this is far too low. The 1978 President's Commission on Mental Health showed that upwards of 15% of the population have significant mental health needs. The elderly are especially vulnerable. For many, they have lost the basic support systems the rest of us take for granted: job, family, income, friends. Their lives are increasingly stagnant. They often feel, with justification, that they have lost control of their lives, are at financial risk, suffer dislocation from traditional living environments, and have great pressures from real physical ailments. Retirees are only recently, and still in only a few places, offered valuable pre and post retirement counseling programs.

For these reasons and the growth of the elderly population itself, GAO reported in September of this year that the Medicare population was in need of more mental health services and greater access to a spectrum of providers.

The current system encourages Medicare to pay for false and inaccurate diagnosis because the mental health assessment is conducted by physicians who have no relevant training but are in control of reimbursement.

The study conducted by Lewin and Associates for the Federal Trade Commission documents that current reimbursement restrictions result in: (1) reduced provider productivity; (2) loss of access to the appropriate range (mix) of service providers; (3) reduction of innovation; and (4) reduced access for poor and rural populations (many of whom are Medicare recipients).

ADAMHA estimates that ⅓ of all health care expenditures are attributable to emotional problems. This would be corroborated by private sector studies which show greater than 50% of physician visits having any emotional rather than physical derivation.

### *The private sector experience*

The patterns of reimbursement discrimination that we are addressing today have also been prevalent in the private sector. For several reasons, these trends are changing. Undeniably, the foremost reason is the presence of state legislation which has opened the employee health benefit to clinical psychologists and, to a lesser extent, psychiatric social workers.

However, employee mental health benefits provided through insurance represents only a segment of the total benefit picture. Major employers have basically rejected traditional insurance as the primary vehicle for providing mental health benefits for problems less severe than those which require in-patient psychiatric treatment.

Employee Assistance Programs, an outgrowth of the older alcoholism programs, have grown from less than 100 in 1970 to an estimate of more than 5,000 in 1981. Typically, EAPs use psychiatric social workers and clinical psychologists, rather than psychiatrists, as staff or for primary referrals.

Trends in employment-based reimbursement policies are:

1. Acceptance of claims from state accredited treatment facilities, regardless of what level of specialist provides the service.
2. Insurance that is capped by dollar amount or number of visits, without regard to provider designation.
3. Acceptance of claims if the referral was from the company Employee Assistance Program. This often means the approval is contingent on referral from a clinical psychologist or social worker.
4. Contracts with provider networks. An example is Human Affairs, Inc. which has more than 800,000 persons covered through such firms as SOHIO, Bell of Pennsylvania, Honeywell, and Utah Power and Light.

Experience from the private employers can be characterized as:

1. Poorly designed benefits are very expensive, regardless of who is reimbursed.
2. Most emotional problems are crisis related, not medical. Thus EAPs are increasingly focused on dealing with legal, family, and financial problems.
3. Ease of stigma-free access to coping-skill counseling is the most important and cost-effective benefit.
4. None of the benefit innovations which use non-physician providers are in conflict with the appropriate use of psychiatrists for either in or out-patient medical care.
5. State licensure is desired—not just professional certification.

6. Peer review systems are increasingly valuable.

7. "Mental and nervous" is the most rapidly increasing element of the medical benefit and thus is causing more employers to turn to EAPs, wellness programs, and other non-medical support systems.

8. No statistically significant difference has emerged in claims' volume between those states with "freedom of choice" law, and those without.

9. Almost no companies reimburse psychiatric nurse specialists directly.

The experience of Human Affairs is informative. They provide employers with a capitated system based on a network of psychiatric social workers. Their experience shows:

1. 60 percent of their cases have a cause that is different from the presenting problem.

2. 40 percent of cases need only 1 or 2 visits; 30 percent are treated to completion beyond 2 visits; 30 percent are referred out. However, many are sent to lawyers or financial agents rather than medical providers.

3. When the program started, they referred 75 percent; now they find that the psychiatric social workers on staff can handle 70 percent of cases.

Another network, the California Psychological Health Plan (and its successor, the California Wellness Network) have produced major reductions in the use of medical benefits for their clients who use the coping skill benefit. A small business example is Keenan Associates (125 employees) which experienced a reduction in average medical claim from $874 to $561 between 1979-80 due to the use of the CPHP counseling program. CPHP is a psychologist network with less than 10 percent of the services provided by psychiatrists.

On a larger scale, programs at the University of Missouri, the US Postal Service, DuPont, and the New York Transit System have all shown positive cost ratios using many non-physician mental health specialists.

Other examples include:

1. Kimberly Clark with a reported 70 percent drop in accidents for EAP participants.

2. In a review of 22 studies on the cost-effectiveness of alcoholism and mental wellness programs, NIMH found reductions of medical utilization which ranged from 5-85 percent.

3. General Motors' EAP has served 44,000 in 130 locations and reports reductions of: 40 percent lost time; 60 percent sickness and accident benefit use; 50 percent grievances; and 50 percent accidents.

All of these examples are offered to show that the need is there, systems using and reimbursing non-physician mental health specialists are proven effective by a variety of measures, and despite employers' concern for medical costs, the trend in the private sector is to increase these services.

### *Recommendations*

The basis of these recommendations is our belief that, ultimately, the most cost effective Medicare mental health benefit design will be the one which uses reimbursement incentives to get patients to the most appropriate provider.

1. Provide direct reimbursement for all categories of licensed mental health specialists.

2. Require and assist in the establishment of mental health peer review systems.

Finally, let me assure you that we make these same recommendations to private sector employers.

### *Conclusion*

There is no good reason for not making the reimbursement changes contained in H.R. 6092. By making the changes, Medicare will be contributing to:

1. More appropriate care.

2. Greater competition in the delivery system.

3. Recognition that many emotional needs are not medical and thus can be more efficiently and effectively served by non-medical providers.

4. Uniformity of the reimbursement rules among major payors.

5. Management of the emotional aspects of chronic illness . . . the cause of 83 percent of restricted activity days and 87 percent of deaths for those over 65.

Thank you for giving us this opportunity to speak on behalf of a small change in legislation which could have a large and very positive impact on the delivery of appropriate care for that most unique element of the human body: the mind.

Chairman JACOBS. Thank you.

Dr. Wilmarth.

## STATEMENT OF RICHARD R. WILMARTH, CHAIRPERSON, GOVERNMENT RELATIONS COMMITTEE, AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION

Dr. WILMARTH. Thank you, Mr. Chairman. I am Dr. Richard Wilmarth, a certified mental health counselor. I am also in private practice.

I represent the American Mental Health Counselors Association and the thousands of professional counselors that provide service across our country.

The title "professional mental health counselor" is not one you heard today. For that reason, I would like to hopefully keep my comments as brief as possible but I would like to request that my entire testimony be included in the record.

Chairman JACOBS. It will be done.

Dr. WILMARTH. We have heard that the issues are freedom of choice, cost effectiveness, competition, quality of care and availability of care.

The American Mental Health Counselors Association, obviously, supports these arguments and we support the testimony that you have received today that justifies the changes requested by way of the Fithian bill.

We have one slight problem. The problem is that we have not been included in this bill. I would ask you, Mr. Chairman, to direct your attention to page 3 of my testimony. One of the most exhaustive studies that NIMH has conducted recently indicates—I refer to the numbers on page 3—that there are 3,000-some psychiatrists available in federally funded mental health centers; there are 5,000-some psychologists available in mental health centers federally funded, there are 6,000-plus social workers available, there are 6,000-plus registered nurses available.

What it does indicate that has not been mentioned here today is that there are 9,000-plus mental health professionals which we are claiming are mental health counselors.

That represents 30 percent of the available delivery system in the mental health team.

One only must examine this on a very cursory level to wonder why mental health counselors have been excluded from this bill.

Historically, the problem that I personally bring to you today is not one that you have not heard before and you have heard it all day today, that other nonphysician core providers have been struggling for recognition that we are now seeking.

These are obviously political battles that occur, but the taxpaying public should not continue to suffer, especially in rural areas.

I think the time has come that all providers of mental health services are allowed to receive direct reimbursement for their services.

I would like simply to close today by quoting Congressman Fithian. He states that "The time has come for the Federal Government to recognize the need to make a fundamental change in the social security system by broadening and expanding coverage to include direct reimbursements to all mental health specialists."

I again say to you today that the time has come to do this, but you must recognize the contributions that mental health counselors are making in the mental health care system in the United States. You must recognize the effectiveness of their services and the cost effectiveness of their services.

I urge you for the good of the millions of people in need of mental health services to support the Fithian bill and to recommend that it be amended to include the professional mental health counselor as one of the specialists involved.

Thank you very much.

[The prepared statement follows:]

## STATEMENT OF RICHARD WILMARTH, ED. D., CCMHC, CHAIRMAN, AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION, LEGISLATIVE AND GOVERNMENT RELATIONS COMMITTEE

I am Dr. Richard Wilmarth, CCMHC, Chairman of American Mental Health Counselors Legislative and Government Relations Committee. I am pleased to offer a statement on behalf of thousands of Professional Mental Health Counselors.

The AMHCA supports the intent of the Fithian Bill, HR 6092. We believe that all professional providers of mental health services should be reimbursed directly for their services.

However, currently this bill does not recognize Professional Mental Health Counselors as one of the identified mental health specialists. This condition exists even in light of recent National Institute of Mental Health data that shows mental health counselors and related masters level practitioners are providing one-third of direct client services in federally funded community mental health centers. Other sources indicate that up to 50 percent of all direct services in both private and public settings are being provided by master and doctoral level counselors. Even though these facts have been available for some time, Professional Mental Health Counselors have yet to be recognized as one of the core providers on the mental health team (i.e., pyschologists, psychiatrists, social workers, and psychiatric nurses).

### WHO ARE PROFESSIONAL MENTAL HEALTH COUNSELORS

Professional Mental Health Counselors typically possess a master's degree or doctorate degree in Mental Health Counseling, Community Counseling, or Community Mental Health Counseling, from a variety of academic departments, including education and psychology. Professional Mental Health Counselors include those persons who typically have a two years master's degree or higher and at least two years of supervised Clinical Counseling experience. Many members of the American Mental Health Counselors Association are licensed by those states that now provide licensure for professional counselors, or are certified by the National Academy of Certified Clinical Mental Health Counselors (NACCMHC) and listed in the register of NACCMHC. The certification process is a competency based on recommendations of the Commission for Health Certifying Agencies. It also involves a comprehensive examination.

### WHERE DO PROFESSIONAL MENTAL HEALTH COUNSELORS WORK

Professional Mental Health Counselors are currently providing direct client services in a variety of clinical settings including community mental health centers, private practice, hospices, and other federal and state mental health agencies. Our members often work along with the other core providers (psychiatric nurse specialists). In many communities underserved by mental health services, professional mental health counselors are the only providers of individual and group counseling for persons needing intervention and preventative mental health care. For the most part, however, professional Mental Health Counselors are often under the supervision of the other "core providers." Over time it has become quite clear that the fact that these mental health professionals cannot practice independently has more to do with the politics of credentialism and problems of "turfism" than the issue competence.

## PROFESSIONAL MENTAL HEALTH COUNSELORS ARE COST-EFFICIENT

The following data is excerpted from the most exhaustive manpower study of mental health personnel across the United States, which was recently performed by NIMH. While the data is extremely detailed, only those items clearly contrasting numbers and types of mental health professionals will be shown for the sake of brevity as well as for the need for awareness of the magnitude of the participation of the "other mental health professional," i.e., not referring to psychiatrists, psychiatric social workers, and psychiatric nurses.

FEDERALLY FUNDED COMMUNITY MENTAL HEALTH CENTERS (CMHC's)

| | Number | Percent |
|---|---|---|
| Mental Health Professions (MA) | 9,714 | 30 |
| Psychiatrists | 3,908 | 12 |
| Psychologists (MA or above) | 5,257 | 16 |
| Social workers (MSW or above) | 6,691 | 21 |
| Registered nurses (AA or above) | 6,524 | 21 |
| Total | 32,094 | 100 |

A cursory examination of the data will show that the largest category of professional treatment staff in a variety of clinical settings is basically Professional Mental Health Counselors. The highest percentage of these counselors are found in community mental health centers, private psychiatric settings, Veterans Administration Hospitals, and individual private practice. The overwhelming numbers of Professional Mental Health Counselors in all of these clinical settings attest to their worth as a part of the clinical team. The problem lies in the fact that these Mental Health Counselors while providing the majority of direct clincial services, do not receive recognition by third party payees. By forcing Mental Health Counselors to look to other mental health professionals to "sign off" for their work, we are adding an increased cost to the provision of mental health service in our country.

Recent data (1978) indicated that two-thirds of the members of the American Mental Health Counselors Association reported salaries from $11,000 to $23,000 with a mean of $17,000. Almost 70 percent of this same sample report their major job duty as "counseling." Another (1981) study showed that 70 percent of Mental Health Counselors in private practice employed a sliding scale fee system—that is, fees based on income. The average fee was $35 for an individual session and $23 for group session. A comparison of this recent salary and fee data to that for the other core providers clearly indicates the cost efficiency of Mental Health Counselors.

Historically, the other non-physician core-providers have struggled for the recognition that we now seek. While we fight such political battles, the taxpaying public continues to suffer, especially in rural areas, by not getting the mental health care they need and/or by paying exorbitant prices for mental health services. The time has come (just as it had for the other mental health disciplines) for Professional Mental Health Counselors to be recognized by mandate for the depth and variety of essential mental health services they provide to thousands of clients each year.

## SUMMARY

Mental Health Counselors are active and well organized and function throughout the country in cities and towns of all sizes. In many underserved communities, both rural and urban, we are often the only service providers for individual and group counseling services. We provide intervention and preventative mental health care. Yet, for the most part Mental Health Counselors are forced to serve under the supervision of the other "core providers." The fact that Mental Health Counselors cannot practice independently and qualify for third party payments has more to do with the politics of "turfism" than the issue of competence. Our cost-effectiveness in mental health services in this era of the New Federalism and fiscal restraint, provides strong justification for the recognition of Professional Mental Health Counselors as a legitimate fifth core of service providers.

If Mental Health Counselors were reimbursed directly for their services (without the need for supervision or "middlemen"), the savings of time and tax dollars could be better spent on additional services to those truly needing mental health care.

The time has come when we can no longer afford to allow only an elite few to provide the vital services needed by so many thousands of our citizens. Day after day, Professional Mental Health Counselors are on the job, providing direct services to those in need at the community level. We must recognize the contribution they are making to the mental health care system in the United States. We must recognize the effectiveness of their services and the cost-effectiveness of this delivery system.

In light of this information, I urge you for the good of the millions of people in need of mental health services in our country, to support the Fithian Bill and to recommend that it be amended to include Professional Mental Health Counselors as one of the identified "mental health specialists."

[Answers to questions submitted subsequent to the hearing follow:]

**AMERICAN
MENTAL HEALTH
COUNSELORS ASSOCIATION**
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PRESIDENT ELECT AND TREASURER EDWARD S. BECK, CCMHC
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January 24, 1983

John H. Salmon
Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Mr. Salmon:

On behalf of the American Mental Health Counselors Association, I am pleased to be responding to Congressman Gradison's questions that you forwarded to me by way of your correspondence of December 17, 1982.

I wish to express my appreciation to Mr. Jacobs, the other members of the House Ways and Means Subcommittee on Health and their staffs for allowing us to present testimony at the hearings concerning Congressman Fithian's Bill 6092.

I will be responding to Mr. Gradison's questions in the order that they were presented.

1. You stated that in 1978, members of the American Mental Health Counselors had an average salary of $17,000 per year. Are mental health counselors and clinical social workers paid at about the same level?

   First, please be advised that the data in my testimony was collected in 1978. Since that time, it would be safe to assume that this figure has increased due to inflation and cost of living increases. Although I have no recent data that would support this information, I feel it would be safe to say that the average salary of master's level mental health counselors has increased from the 1978 figure of $17,000 to approximately $19,000 - $20,000 per year. By comparison, according to the Occupational Outlook Handbook (1982-1983) the starting salaries for bachelor level social workers in state and local government averaged about $12,000 in 1980. For supervisors, the average salary was $15,900. For master's level social worker with one year of related experience in hospitals and medical centers, the average salary was $16,300. The upper limit for the master's level social worker appears to be approximately, on the average,

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$21,000. In the federal government however, master's level social workers with no experience were starting at $18, 585 in 1981 with average earnings of $25,200 for the year.

As these figures suggest, the master's level social worker and the master's level mental health counselor probably earn similar amounts in settings where both are employed to provide mental health services. In private practice, I would suspect the per session charges fall somewhere in the range of $30 - $45 per hour, depending upon the location of the practice (urban areas representing the upper limit of this range).

The only noticeable difference in the earnings between master's level social workers and mental health counselors would be found by the comparison of the level of degree held by the practitioner. Doctoral level mental health counselors, who represent less that 30% of our membership, would most likely be earning larger salaries in both private and agency settings. This would also be true of doctoral level social workers.

2. I note that, based on data from the CHAMPUS program, nonpsychiatrists, psychologists are paid on average, around $44 for counseling/psychotherapy sessions of 45-50 minutes. By my back of the envelope calculations, a person charging such fees could potentially earn on the order of $88,000 per year based on a normal 40 hour work week. Could you please explain to me how it would be possible to increase reimbursement to that extent and still save money?

My understanding of the Fithian Bill is that it is attempting to increase the number of providers that would be eligible for direct reimbursement for providing services to Medicaid/Medicare recipients. The bill is not asking Congress to increase the amount of monies provided for these services. We are supportive of the bill's intent to establish professional parity for providing comparable services, but we are not suggesting, nor would we be requesting that more money be allocated. We are suggesting that freedom of choice be afforded the consumers of these services.

Regarding the notion of cost-effectiveness, I suggest that if mental health practitioners were reimbursed directly for their services, there would be no middleman expenses incurred, thereby reducing the cost of these services. Likewise, the natural competition resulting from the increase in the numbers of providers in the marketplace would tend to lower the overall cost of these services to the public.

Concerning your "back of the envelope" calculations, I submit the following:

- * The average number of sessions held by the effectively functioning counselor is between 20 and 25 sessions per week. To hold more sessions per week means the practitioner is either "money-hungry" or "ineffective" or both.
- * A counselor in private practice pays all of his or her own expenses, i.e. rent, insurance, retirement, etc., while the agency persons' espenses are paid by the agency.
- * The cost-effectiveness of utilizing private practitioners has been recognized by many state agencies who have begun to here private practitioners to see agency clients. The agency collects a fee from the practitioner for office use and then pays a set fee for the service provided. In this situation, the agency does not pay any expenses such as insurance or other benefits, thus reducing the overall cost of these serivces to the public.

3. You stated in your testimony that a study for the American Mental Health Counselors Association indicated that 70% of the members reported their major job duty as counseling. Just what is counseling and how is it different from psychotherapy?

The issue of counseling versus psychotherapy is more of an interprofessional/theoretical issue than a consumer issue. Although this matter is still being debated among the various practitioners within the mental health delivery system, the purposes of this piece of legislation is appropriate to consider them to be of like kind.

I have taken the liberty to include additional information by way of attachments A and B that should assist you in your efforts to become familiar with the definition, role and training of the mental health counselor.

4. Why do you believe Medicare should pay for counseling services on a fee-for-serivce basis and couldn't these services be provided on a more efficient and less costly basis under a salary arrangement in an organized setting?

In answering this question, I would only like to reiterate my response to question #2. The private practitioner can give the needed services less expensively, due to the fact that the overhead is included in his or her fee. On the other hand, agency charges are similar on a fee basis and they also seek additional funds to pay for their overhead. I believe it is a general misconception among the majority of Americans that mental health services can be provided in a more cost-effective basis under salary arrangements in an organized setting. This misconception is due to in part to the decreased fees charged by community mental health centers and other agencies in which the clients' current income is assessed and fees derived from a sliding scale based on their ability to pay. This formula results in a lower fee on the surface, but the overall cost of providing these services is increased.

With the current administration's emphasis on cutting back federal support via grants for agency delivery systems and training, more mental health practitioners are being forced to consider establishing private practices. Making third party reimbursements available from all sources is a necessary condition if these practitioners are to be given an equal opportunity to make a living at their chosen profession. To do otherwise would only exacurbate the current "restraint of trade" that now exists within the medical/mental health care delivery system.

Please accept my sincere thanks for this opportunity to provide you with the above information. If you need additional data, or would like for me to clarify any of the information presented, please let me know.

Sincerely,

Richard R. Wilmarth /srd

Richard R. Wilmarth, Ed.D., CCMHC
Chairperson
National Legislative and Government Relations Committee

RRW/srd

CC: Board of Directors, American Mental Health Counselors Association
Robert Rencken
Patricia Hooper
Joe McDonough
Len Perlman
Harley Dirks
Dale Dirks

Attachments

# What is counseling?

*Counseling, simply stated, is the art of helping people. Professional counselors are individuals trained to share knowledge and skills with those who need help. Counseling recognizes that all persons need help as they routinely pass through childhood, adolescence, and adulthood. Effective counseling is preventive. Counselors help persons with their personal, social, career, and educational development. Counselors serve people through schools, colleges, community agencies, and private practice.*

## Where do counselors work?

*Counselors can be found in these educational and social service settings:*

*Schools*
*Colleges and universities*
*Mental health agencies*
*Rehabilitation agencies*
*Correctional facilities*
*Public employment agencies*
*Private practice*
*Community agencies*
*Business and industry*

## What do counselors do?

*Professional counselors help all people with their personal, social, career, and educational needs. The typical human concerns that counselors deal with include:*

*Personal and social development/problems*
*Career and educational guidance*
*Mental health/mental hygiene*
*Physical and vocational rehabilitation*
*Unemployment and underemployment*
*Reentry (school and work)*
*Substance abuse (drugs and alcohol)*
*Family and marriage concerns*
*Parenting*
*Aging*
*Child abuse*

## How many counselors are there?

*It is estimated that between 100,000 and 125,000 professional counselors work in America. The majority of these persons are employed in educational settings but recent trends suggest a significant growth of counselors in mental health, community agency, and private practice areas.*

## What kind of training does the typical counselor have?

*Counselors prepare for their roles by studying in a master's degree program at an accredited college or university. While most of these programs are affiliated with schools of education, counselors have had extensive study in related schools of psychology, sociology, mental health, and human resource development.*

*In addition to their classroom studies, counselors have a practicum or internship experience, a structured opportunity for the student counselor to practice his/her skills and competencies under the careful supervision of an experienced professional counselor. Practicing counselors enrich their professional skills in participating in in-service and professional development programs.*

## What group represents counselors?

*Since its founding in 1952, the American Personnel and Guidance Association has been the professional organization representing counselors in America and the world. APGA is the parent organization for 13 divisions, four regional assemblies and 54 state branches (50 states, District of Columbia, Europe, Puerto Rico, and Latin America). APGA, through these composite parts, addresses the interests of counselors in every work setting, and provides an opportunity for members to become involved at the regional, state, and local level.*

## Mental Health Counselors Need to be Recognized as A Core Provider of Care, and made Eligible for Reimbursement

I. Membership

- A. American Mental Health Counselors Association members number more than 6,000
- B. Affiliates of 40,000 member American Personnel and Guidance Association
- C. Members from 47 states, District of Columbia (and small groups from Canada, Mexico, South and Central America, and Europe.)
- D. Average age of AMHCA member is 37. Two-thirds are between the ages of 27-47.

II. Education

- A. 72% have masters degree...16% with doctorates
- B. 89% have received their degree within the last ten years
- C. 70% have between three to five years counseling experience
- D. Although in 1980, the National Academy of Certified Clinical Mental Health Counselors was less than one year old and the counseling license movement had just begun, 21.4% of Members not in private practice, and 43.9% or members in private practice, held some type of professional degree

III. Mental Health Counselors are on the Job

- A. Members employment setting (1978):
  - a. Community mental health centers 39.10%
  - b. Private practice 18.07%
  - c. College counseling centers 9.04%
  - d. Private agencies 7.83%
  - e. State agency 6.93%
  - f. College Professors 6.93%
  - g. Student 1.50%
  - h. Other 9.64%
  - i. Unemployed .90% (a very low unemployment rate.)
- B. In Spring of 1980, 37% of members were in private practice. 45% or those not in private practice intend to be in private practice within three years.

IV. Mental Health Counselors make a difference in peoples lives

A. Estimates as high as 50% of direct delivery of mental health services are provided by Mental Health Counselors

B. Counselors receive most patient referrals from physicians, former clients, and professional colleagues. Additional referrals are received from schools, the clergy, courts, social agencies, business and industry.

V. What do Mental Health Counselors do?

A. Job Descriptions and earnings:
The following are the brief job descriptions of Mental Health Counselors:
1. Counseling 66.87%
2. Administration 17.4%
3. College teaching 9.04%
4. Consulting 3.01%
5. Remainder are students, psychologists, other

B. Professional labels used by Mental Health Counselors
1. Counselors 23%
2. Marriage and family counselors/therapists 19.5%
3. Psychotherapist 11.79%
4. Psychologists 7.8%
5. Mental Health Counselors 5.6%

C. Average Salary and cost effectiveness
1. Mean salary per year in 1978 was $17,000. 2/3 of members have salary range between 11,000 and $23,000
2. Mean fee in 1980 for individual sessions was $35,00. $23.00 for group sessions. (Compare this with other mental health care professional's fee) .

VI. Mental [illegible]h Counselors set high Standards for Themselves

A. [illegible] onsidered for classification as a Certified [illegible]l Mental Health Counselor a member must:
1 [illegible]d a Masters or Doctorate degree from a regional [illegible]credited university.in clinical health [illegible]eling or in an allied mental health field [illegible]also:
[illegible]ave a minimum of two years post masters experience in a mental health settings with:
· A minimum of 1,500 supervised clinical hours per year with:
A minimum of 50 hours documented face to face supervision per year
2. Hold a masters or doctorate degree from a regional accredited university in clinical mental health counseling or in an allied mental health field and have a minimum of five years post masters in field work experience in a mental health setting.

Mental Health Counselors are cost effective and provide quality care.

045.XXX-XXX Mental Health Counselor (profess. & Kin.) Guidance, Counselor, Therapist, Social Worker

Performs counseling/therapy with individuals, groups, couples, and families: collects, organizes, and analyzes data concerning client's mental, emotional, and/or behavioral problems or disorders; aids clients and their families to effectively adapt to the personal concerns presented; develops procedures to assist clients to adjust to possible environmental barriers that may impede self-understanding and personal growth. Frequently works in collaboration with other helping professionals, such as PSYCHIATRIST, CLINICAL PSYCHOLOGIST, PSYCHIATRIC NURSES, and CLINICAL SOCIAL WORKERS. Utilizes community agencies and institutions to develop mental health programs that are developmental and preventative in nature. Trained to provide a wide variety of therapeutic approaches to assist clients, which may include therapy, milieu therapy, and behavioral therapy. Employed in clinics, hospitals, drug centers, colleges, private agencies, related mental health programs, or private practice. Required to have knowledge and skills in client management, assessment, and diagnosis through a post-graduate degree program in mental health or community mental health counseling.

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## MENTAL HEALTH COUNSELOR

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Certified Clinical Mental Health Counselor
Clinical Mental Health Counselor
Community Mental Health Counselor

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Mental health counselors work in a specialized field of counseling which emphasizes the developmental and adjustive nature of mental health services. Mental health counseling includes the utilization of individual and group counseling techniques oriented toward teaching individuals: (1) methods of problem-solving; (2) personal/social development and decision-making; and (3) the complex process of developing self-understanding and making life decisions.

Working in conjunction with other helping professionals, such as psychiatrists, physicians, psychologists, and social workers, the mental health counselor determines the most appropriate counseling intervention for each client. Frequently, the counseling intervention for the client includes involvement with other individuals in the client's environment, especially the family. Mental health counselors work in psychiatric hospitals, community mental health agencies, private clinics, college campuses, rehabilitation centers, and private practice.

Mental health counselors differ from other helping professionals in that their role in mental health is primarily developmental and preventative. In addition, although some mental health counselors may have a research background, they function on an applied basis utilizing accepted techniques of individual, group, family, and crisis intervention counseling. The mental health counselor is trained in a variety of techniques and therapeutic interventions which enable him/her to function independently or with a team of helping professionals.

The main responsibility of the mental health counselor is to offer therapeutic assistance to clients to assist them in resolving identified problems and concerns. Typical work activities include: (1) individual and group counseling/therapy sessions; (2) marriage and family counseling/therapy; (3) completing formal and informal assessments; (4) vocational and career counseling; (5) applying intervention strategies for such problems or concerns as rape, abortion, and abuse; and (6) mental health consultation. The mental health counselor is also responsible for knowing the applications and limitations of family therapy, behavior modification, transactional analysis, and many other commonly accepted forms of therapeutic intervention.

During the past ten years, mental health counseling has become a specialized area of advanced graduate training in counseling/therapy. Mental health counselors are committed to the idea that clients can improve with help; mental health services must be open to change; different cultural and individual life styles should be respected; and self-development is a continuing lifelong process.

### Job Requirements

Educational requirements for the mental health counselor typically include a bachelor's degree plus a master's degree from an accredited graduate program in counseling. According to the standards of the Association of Counselor Educators and Supervisors, American Mental Health Counselors Association, and the Council for the Accreditation of Counseling and Related Educational Programs, the student is usually required to complete training and experience equivalent to two years of graduate study. The field experience usually includes 600 clock hours of individual or group counseling with clients as well as being a part of a professional staff in an agency, institution, or school. The following coursework is suggested for mental health counseling: theories of human behavior; abnormal behavior; mental health intervention; individual counseling techniques; group counseling techniques; drugs; evaluation, assessment, and research; community mental health needs; ethics; and supervised practicum.

Presently there is a national certification process for mental health counselors operated by the National Academy for Certified Clinical Mental Health Counselors. The basic requirements for being a certified Clinical Health Counselor are: 3600 clock hours of didactic and experiential training, including 1600 hours of internship with a minimum of 200 hours of supervision. Mental health counselors are represented nationally by the American Mental Health Counselors Association, a division of the American Personnel and Guidance Association. In addition, counselor/ licensure is possible in six states for counselors at this time (Alabama, Arkansas, Florida, Idaho, Texas, and Virginia).

Opportunities

Job opportunities are many and varied for mental health counselors at this time because the developmental nature of the services provided by a mental health counselor is much in demand. Opportunities exist in hospitals, institutions, schools, colleges, agencies, and for private practice. There are many mental health programs throughout the country that utilize mental health counselors as integral parts of professional teams assisting individuals, groups, or institutions. Also, mental health counselors are coordinating preventative mental health programs in a variety of settings.

Depending on the level of training, either master's or doctorate, a mental health counselor can function as a team member or be a supervisor of a mental health program. Therefore, the opportunities for professional growth and career ladder mobility within the profession are quite numerous and dependent upon experience, training, leadership ability, and level of education.

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For further information, contact:

American Personnel and Guidance Association
American Mental Health Counselors Association
National Academy of Certified Clinical Mental Health Counselors
Council for the Accreditation of Counseling and Related Educational Programs

Chairman **Jacobs**. Thank you very much, Dr. Wilmarth.

What do you think about that?

Mr. **Goldbeck**. I can certainly understand his problem. In the private sector, I don't think we have any experience that would be valuable to you in assessing whether that particular component should be added.

I am philosophically sympathetic but I don't have any numbers to give you.

Chairman **Jacobs**. Counsel?

Dr. **Carter**. There is significant evidence in an HMO setting that the use of mental health services can reduce other medical utilization. Do you have evidence that this occurs among any of your employers whether it is a fee for service or whatever?

Mr. **Goldbeck**. Yes, we have evidence and reports from companies of varying sizes. I cite two in the testimony, one small one in California that has used this in a year in which health care costs went up dramatically in California, and their costs went down by a third directly attributable to reduced medical use through imposition of a counseling program, a coping skills level program.

One thing that may be important to include in this discussion is that none of the additional professionals ought to be in any way perceived as threatening to the appropriate services of the medical profession themselves. They are not in conflict.

Dr. **Carter**. Thank you.

Chairman **Jacobs**. OK; we appreciate your testimony.

Our final witness today is Dr. Leonard Saxe, department of psychology, Boston University.

## STATEMENT OF LEONARD SAXE, PH. D., DEPARTMENT OF PSYCHOLOGY, BOSTON UNIVERSITY

Chairman **Jacobs**. Welcome to the committee, Dr. Saxe.

Dr. **Saxe**. Thank you, Mr. Chairman, for inviting me to testify today.

I am Leonard Saxe, and I appear before the committee as an individual. I am a research psychologist and assistant professor of psychology at Boston University. I was formerly study director of the Congressional Office of Technology Assessment study of the cost-effectiveness of psychotherapy. I am currently working with the Office of Technology Assessment on the study of alcoholism and the effectiveness of treatment.

Rather than read my statement, I would like to submit it for the record and summarize my conclusions. I would also like to make available to you and other members of the committee copies of the Office of Technology Assessment Report on Psychotherapy.

Chairman **Jacobs**. Without objection, it will be included in the record. [The report is in the subcommittee's files and is not reproduced here.]

Dr. **Saxe**. As noted in my testimony, my duty as a researcher is to complicate matters.

Yes, I believe that extending independent provider status to mental health specialists as provided for in the bill under consideration is probably necessary and redresses a problem in how medicare functions. It would make medicare consistent with other health insurance programs, provided by the Federal Government and private insurance companies.

However, while correcting the provider status problem is reasonable, in and of itself such a change will not improve the availability and quality of mental health care.

My personal view is that the present system is inefficient, poorly coordinated and has not well-enough applied research findings to the development of treatment programs. What is needed is a system that matches patient problems, therapists' skills and approaches to therapy. There is a large matrix of problems that patients present and the available resources of providers and provider systems.

I can give you an example from the field of alcoholism. Clearly, alcoholism has medical components. But people drink for various reasons, many of which have psychological and social bases. Hospitalizing an individual who is severely impaired because of alcohol use may, under certain conditions, be necessary. However, it may also be necessary to treat such individuals by giving them various forms of counseling, by making interventions in their family system, and helping in various ways that do not involve medical treatment. The requirement that such treatment be supervised and/or ordered by a physician, results in costs that are higher than necessary. As well, many of our Nation's perhaps 10 to 15 million individuals who suffer in some way from problems due to alcohol abuse do not get assistance.

To develop a coordinated system to deal with alcoholism, as well as other mental health problems, is undoubtedly difficult. What may be needed is an emphasis on organized mental health settings, health maintenance organizations, community mental health centers, and so forth. It may also mean that one has to develop quality assurance programs, and pay attention to coordination issues among delivery settings, mental hospitals, CMHC's, and so forth.

One approach to sorting out the complexities of matching patient problems and provider capabilities is in a bill currently before the Senate, S. 647. The bill, introduced by Senators Matsunaga and Inouye, would establish a national Professional Mental Health Services Commission. The commission would advise the Secretary of the Health and Human Services Agency, and would be charged with an evaluation of scientific evidence as to effectiveness of mental health treatments. The Commission would provide advice to the Secretary about the conditions under which reimbursement should be made for mental health treatment. I emphasize the latter statement, the conditions under which treatment should be provided. My analysis is that the problems are so complex we cannot have a simple formula for identifying which provider at which point in treatment should receive reimbursement or should deliver care.

There are clearly approaches to the problem other than the Matsunaga-Inouye bill. The goal, however, should be kept in mind of improving the quality and availability of cost-beneficial care. Recent evidence indicates that mental health treatments can be effective. The task before us, as a Nation is to insure that the best possible treatments are offered.

Thank you.

[The prepared statement follows:]

### STATEMENT OF LEONARD SAXE, PH. D., DEPARTMENT OF PSYCHOLOGY, BOSTON UNIVERSITY, BOSTON, MASS.

Mr. Chairman and members of the subcommittee, I am pleased to appear before you to discuss provision of mental health treatment for individuals covered by the Medicare Program. I am an Assistant Professor of Psychology at Boston University and I formerly served as study director for the Congressional Office of Technology Assessment's (OTA) project on the cost-effectiveness of psychotherapy. My doctoral training is in social psychology and I specialize in evaluation research and health policy. I am not a licensed clinical psychologist, and I do not practice as a mental health provider. In addition to my work on psychotherapy research, I have served as a consultant to OTA on various matters and have prepared analyses on medical technology assessment and, currently, on the effectiveness of alcoholism treatments. I am also the senior author of a recent book, "Social Experiments: Methods for Design and Evaluation." I appear before the subcommittee as an individual and my views do not necessarily reflect those of the Office of Technology Assesssment.

*Issues.* The issue as to who should be authorized, under Medicare or Medicaid programs, to provide mental health services is extremely complex. Facile solutions, such as expanding the number of professionals who can receive reimbursement, while probably necessary and desirable, may not go far enough in correcting problems with the current mental health system. Present regulations, which permit nonpsychiatric physicians to provide mental health care and supervise mental health specialists, are probably neither appropriate nor efficient, but simply broadening the number of providers will not by itself improve care. Mechanisms must be developed to assure that treatment is appropriately matched to patient needs and is coordinated among health practioners.

Perhaps, as a researcher, it is my duty to complicate problems rather than to offer particular solutions; nevertheless, I believe that the problem of independent provider status must be considered within the terms of the context of mental health problems and on understanding of treatments. Widespread agreement exists about the seriousness of mental health problems and their effect on the physical, social, and psychological well-being of many Americans. The goal of any legislative remedy must be to improve the quality and availability of services to ameliorate these problems, rather than to merely redress inequities in how professional groups are treated. An effective mental health system will necessarily be complex, but I believe we have the scientific tools and understandings to create such a system.

#### OTA STUDY OF PSYCHOTHERAPY

In order to provide context for the present discussion, I would like to describe briefly the study of psychotherapy cost-effectiveness conducted by the Office of Technology Assessment during 1979-80. The study was requested by the Senate Committee on Labor and Human Resources and by the Senate Committee on Finance. There was a general concern with the effectiveness of psychotherapeutic treatments and the potential costs and role of mental health treatments within a national health insurance program. The Senate Finance Committee, in particular, was concerned with the scientific basis for mental health treatments and which, of the large number of treatments available, can be considered effective according to standard scientific criteria.

Parallel to OTA's work on the psychotherapy study, a bill was developed by Senators Matsunaga and Inouye to establish a National Professional Mental Health Services Commission (currently, S. 647). The Commission would operate with social security trust fund monies and would be charged with evaluating the scientific evidence as to the effectiveness of mental health treatments. Their most important task would be to identify the conditions under which mental health services should be reimbursed. The Commission would also be able to support research to address questions not currently answered by available scientific evidence.

The proposal to establish a commission was consistent with a principal conclusion of OTA's psychotherapy study. OTA found that a host of variables affected outcomes of mental health treatments. Although mental health/psychotherapeutic treatments are most often differentiated (by lay persons and professionals) in terms of their theoretical orientation (e.g., psychoanalytic), in fact, a number of other variables significantly affect outcomes. Variables such as patient characteristics (including the nature and severity of the patient's condition), characteristics of the delivery setting and characteristics of mental health professionals all affect treatment effectiveness.

The professional affiliation of the therapist/mental health provider is only one of a large number of potentially important factors.

The OTA report also investigated the scientific basis of evaluations of mental health treatments. Although some have regarded psychotherapy and mental health treatments as unscientific, there is no a priori reason why mental health research cannot meet methodological criteria of research in other health areas. In fact, there is a great deal of such work, varying from experimental controlled clinical studies to descriptive non-clinical studies. One central problem in evaluating any mental health treatment is determining which of many outcomes should be assessed. Despite difficulties, reliable and valid measures have been developed to assess a broad range of these outcomes and there is surprising agreement among them.

In reviewing the substantive literature reporting assessments of psychotherapeutic treatments, OTA found an interesting trend. Whereas reviews conducted as recently as 20 and 30 years ago were negative (or, at least neutral, in that a provable connection between treatment and outcome could not be established), more recent reviews find substantial positive evidence. This trend to find positive effects for mental health treatments cannot, as some cynics suggest, be attributed to poor research. The more recent the research, the more likely it is to be scientifically rigorous and to employ quasi and true experimental designs (i.e., control group or randomized control group research designs). Thirty years ago it may have been justified to claim that someone who receives a mental health treatment is not more likely to get better than someone who has not, but the evidence today is far more positive. Recent indications are that, on average, three-fourths of those who receive mental health treatments receive significant help over and above any improvement that might occur without such treatments.

A particular focus of the OTA psychotherapy report was the cost-effectiveness of treatment. Cost-effectiveness analyses, and parallel cost benefit analyses, are tools which everyone uses. We do it with our family budgets and our day-to-day spending decisions and those of you with legislative responsibility apply it on a larger scale. The techniques, however, are sometimes deceptive. The problem of applying cost-effectiveness and cost-benefit analyses to mental health is that while costs are often obvious (e.g., therapists' charges), benefits are more difficult to evaluate. Thus, for example, what has been called bibliotherapy (i.e., reading a self-help book) is an extremely low-cost mental health treatment. The result is that bibliotherapy does not have to help a person very much to be beneficial. Claiming that bibliotherapy is cost-beneficial begs the central policy question. It may not be effective for a wide range of problems and its effectiveness may not be great enough, despite its low cost, for us to employ it very often.

## IMPLICATIONS

There are several implications of a careful review of data about the mental health system and research evidence that are directly relevant to the problem of who should be authorized to provide mental health treatments. One implication is that realities of available personnel resources must be considered. In addition, interactions between medical and non-medical treatments of mental disorders must be considered. Finally, although data are not readily available, inferences can be made about the effects of provider affiliation.

*Personnel.* When, in the late 1950's Congress established a Joint Commission on Mental Illness and Health, it was recognized that there was a growing shortage of psychiatrists. There were not enough American trained psychiatrists and, increasingly, foreign trained physicians were providing therapy in public treatment settings. The shortage of psychiatrists is even more severe today and those who are available are grossly maldistributes. What is different about today's situation, in contrast to that of the 1950's, is that there has been a dramatic growth in the number of clinical psychologists, social workers, psychiatric nurses and other health personnel.

Means must be developed to utilize these non-medical mental health specialists. In 1978, the President's Commission on Mental Health estimated that over 30 million Americans had some significant emotional disorder, but that the mental health system was only able to treat one-fifth of these individuals. One important trend is that, increasingly, individuals are being treated in community mental health facilities. Many such facilities, because of affiliation with hospitals and other medical units, are able to receive Medicare reimbursement for treatment offered by non-physicians. Since psychiatrists represent only a small portion of available mental health personnel, such arrangements are necessary if services are to be provided on a wide scale.

*Interactions.* Certain psychiatric treatments, principally those based on the use of psychoactive drugs, and those used to treat organic problems, must be handled by medically trained personnel. It is clear, however, that such disorders represent only a small portion of mental health problems. Most disorders represent an interaction between medical and non-medical components. A useful example of such interactions is provided by the problem of alcoholism. For over 25 years, alcoholism has been acknowledged as a disease; nevertheless, most recent definitions (e.g., the American Psychiatric Association's Diagnostic and Statistics Manual) indicate that alcoholism is based both on physical and psychological dependences to the drug ethanol. For reimbursement of treatment purposes, alcoholism is generally considered a psychiatric disorder.

Alcoholism and alcohol abuse are, perhaps, our nation's most serious health problem, directly affecting between 10 and 15 million individuals and significantly adding to our overall health care costs. A wide variety of treatments are available to treat alcoholism and alcohol abuse. Most such treatment programs are multivariate and include both medical and non-medical components. Obviously, for severely impaired alcohol abusers, it is necessary to detoxify and manage withdrawal, perhaps using drugs. Drugs, as well, are used as part of various treatment programs, to prevent patients from ingesting alcohol or to train them to dislike alcohol. Whatever treatment is used; however, a non-medical component including psychotherapy, family treatment and social support is typically seen as necessary. The problem of developing an effective alcoholism treatment system is one of meeting differential needs of patients impaired by ethanol dependency. An emphasis on medically based treatment, especially if it involves inpatient hospitalization, increases costs without necessarily resolving the root problem. The same may be true for other health problems.

*Research on providers.* This returns us to the direct issue of who should be authorized to provide mental health services. There is, unfortunately, little directly relevant research. To be sure, there are studies of the effectiveness of treatment provided by different professionals. Few of these studies directly compare services offered by providers of differing professional affiliation. So many other factors, such as the experience of the therapist, the availability of consultation or referral of other therapists and the setting within which therapy takes place need to be considered that it is doubtful such research would be conclusive.

Although the literature does not indicate that, for example, social workers or psychologists are equally as effective as psychiatrists, neither does the literature support the reverse hypothesis that psychiatrists are more effective. There are some findings which indicate that length of training and experience is positively associated with outcome, but such studies are difficult to apply directly to the problem of the nature of professional training. It should also be noted that a number of studies indicate that nonprofessional therapists (e.g., mental health workers, alcoholism counselors) provide therapy more cost effectively than medical, psychological, or social work staff. Such data should be treated cautiously, however, since the problems that such paraprofessionals deal with may be different and the effectiveness of treatment may depend very greatly on the availability of the supervision by other professional resources.

## CONCLUSIONS

Extending independent provider status to well-trained specialists, such as psychologists and social workers, makes reasonable intuitive and practical sense. Research evidence does not permit segregation of the unique effects of particular professional affiliations. It is clear, however, from the vast research on psychotherapeutic effectiveness that mental health specialists, not limited to those with medical degrees provide effective treatment. A system must be developed, however that insures appropriate treatment-patient matches and makes use of the best available research information on mental health treatment.

*Coordinated system.* We need to shift to a mental health system where the necessary team of professionals and non-professionals can be assembled to provide treatment. For different reasons, or at least different points in treatment, providers from different disciplines may be required. We need to insure that the correct level of treatment is provided and that quality care is delivered. Such requirements suggest a system in which physician approval for treatment is not required. Although medical and non-medical coordination is necessary, for mental health treatment, a hierarchical arrangement may be dysfunctional. The organization of care will, necessarily be dependent on the nature of the patient's problem. The failure to develop a system that can assign patients to appropriate treatments will mean that the overall costs of health care will be greater than necessary.

*Research.* A second conclusion is that there is a great need for research on mental health services. Many of the questions being asked by the subcommittee, by your colleagues on Representative Waxman's subcommittee and by many interested in mental health policy are questions for which we currently do not have answers. We need to develop a program of research which will allow us to answer questions about patient problems, approaches to treatment, treatment setting, and provider characteristics that maximize outcomes. Mental health problems are complex and research will be difficult to conduct and assimilate; nevertheless, such work is necessary if we are to improve our ability to ameliorate the effects of emotional disorders.

One model for both stimulating the necessary research and insuring that it is utilized is the establishment of a National Commission, along the lines proposed by Senators Matsunaga and Inouye. Such a commission would be able to identify the complex conditions under which effective and cost-beneficial treatment can be offered. To be sure, there are other approaches, such as expanding the resources of the Alcohol, Drug Abuse and Mental Health Administration. Our goal must be to develop valid and usable knowledge.

Thank you Mr. Chairman. I would be pleased to answer any questions that you or members of the subcommittee would care to address.

[Subsequent to the hearing Mr. Gradison submitted the following questions:]

*Question 1.* There seems to be considerable controversy over the efficacy and appropriateness of some forms of mental health treatment. What is "jogging" therapy, "poetry" therapy, "dance" therapy, "rage" therapy, "sex surrogate" therapy, "primal scream" therapy? To what extent are these modes of treatment utilized? How many different types of therapy are there and how valid are they?

Dr. SAXE. It is difficult, and I think unproductive, to develop a list of the different types of psychotherapy according to their popular lables. From a scientific standpoint, the labels referred to in your question are poor descriptors and one would not want to assess their validity. Although therapies, such as "dance" therapy and "sex surrogate" therapy are sometimes discussed in the professional literature, they indicate only the milieu in which therapy is conducted or some aspect of the therapeutic procedure. In an analogous way, surgery is sometimes called "going under the knife", but one would not evaluate "knife therapy". Any typology must deal with the underlying theory, rather than aspects of the procedure. Perhaps, most importantly, in terms of reimbursement questions one would not want to pay therapists to conduct these therapies, although these procedures or activities might be included/recommended by a therapist.

In the Office of Technology Assessment's psychotherapy case study, great effort was made to develop a typology of psychotherapies that avoided the popular labels. The result was an organization of psychotherapies according to theoretical bases and identifications of the factors that affect psychotherapeutic effectiveness.

*Question 2.* Is there quackery in psychology and, if so, what steps have been taken by the profession to deal with it?

Dr. SAXE. Quackery is defined as treatment provided by untrained practioners. Although, undoubtedly, individuals have called themselves psychologists without the requisite graduate training and certification, my impression is that the profession of psychology has acted vigorously to enforce training standards and to encourage states to regulate psychotherapy. With the support, and in some cases pressure of organized professional psychology groups, states have developed licensing examinations and criteria for advertising as a psychologist. In addition, under the auspices of the American Psychological Association, a national register of those certified as psychologists have been developed.

The regulation of psychotherapy is somewhat outside my preview as a researcher and non-clinician, but the regulatory activities I have described and the efforts of professional groups have been very prominent as well as public. There has been continual discussion of the need for these steps and some have regarded efforts of professional societies such as the American Psychological Association as too strong (e.g., because they have not fully recognized Master's level training, only doctoral), they view the standards as too stringent and as restraints to competition. It is clearly a difficult balance.

*Question 3.* Can you cite specific instances where the profession has publicly taken action against certain methods of treatment or unproven claims?

Dr. SAXE. Representatives of the American Psychological Association and state Boards of Psychology have available more precise information than I about specifics.

I am knowledgeable, however, as to the ethics review procedures of the American Psychological Association. The American Psychological Association has an extensively developed code of Ethical Standards for Psychologists. The first principle of the standards requires that psychologists maintain the highest standards of practice and use appropriate treatment methods. The second principle requires that psychologists accurately represent their competence and education. In addition, State Boards of Psychology, which have the primary responsibility for licensing, carry out investigations of individuals.

My impression is that the profession has taken strong measures to monitor and deal with provision of efficacious treatment. Each year a number of cases are heard by the ethics committee and sanctions or explusion from the American Psychological Association result. However, professional groups such as the American Psychological Association can work only within state and federal regulations. They are, as weli, limited by the availability of research data. Unfortunately, too little is known about which treatments under which conditions are most effective.

*Question 4.* To what extent can mental health practitioners generate demand for their services without anyone being able to effectively evaluate the appropriateness of that demand?

Dr. SAXE. The question is difficult to respond to because it depends on the system within which the mental health practitioner works and is paid. If, for example, treatment is offered within a community mental health center or other institutional facility, there would seem to be a lessened chance that practitioner-induced demand will be a problem. As evidence, consider that mental health treatment has become a permanent feature in many health maintance organizations. In such settings, controlling health care costs is a principal objective, yet mental health services have been found to be cost-beneficial.

In non-institutional settings, two elements would seem to control demand: (1) psychotherapy is a difficult process, and even if practitioners were encouraging treatment, patients would not necessarily continue; (2) since co-payment is a part of the system, patients have strong incentives to terminate therapy. This is not to say that practitioner-induced demand is not a problem. It is a potentially serious problem were reimbursement for mental health problems to be broadened, but there are a number of ways to control its effects including institutional, patient, and peer review mechanisms.

*Question 5.* In medicine, there is a generally accepted consensus concerning modes of diagnosis and treatment. In the treatment of mental conditions, what are the generally accepted procedures and theories of diagnosis and treatment? Does this vary between psychiatrists? Does this vary between psychologists? Does this vary between psychiatry and psychology?

Dr. SAXE. I do not share the premise of your question. There are many medical problems for which there is not consensus about treatment. It is for this reason that the National Institutes of Health has had as a priority developing procedures for Consensus Development exercises. There are many medical procedures for which consensus does not exist and for which little valid research evidence is available. A number of these problems in medical decision-making are described in a recent Office of Technology Assessment report.

### STRATEGIES FOR MEDICAL TECHNOLOGY ASSESSMENT

In mental health, lack of agreement about procedures, both within and psychology and psychiatry and other mental health disciplines surely exists. Nevertheless, for diagnosis, the most recent "Diagnostic and Statistical Manual (DSMIII)" published by the American Psychiatric Association is widely accepted. Although there are differences between psychiatrists and psychologists, particularly in treatment of mental disorders, the effort of different mental health specialties is not mecessarily contradictory. My view of appropriate care is that the disciplines need to collaborate and that the government, through its health insurance initiative, can do much to encourage cooperative efforts.

*Question 6.* With respect to the diagnosis and treatment of mental illness, and based upon demonstrated scientific research what types of insurance coverage do you believe we can provide with reasonable confidence?

Dr. SAXE. At this point, all I can to say is that the evidence seems to indicate that treatment, in general, is better than no treatment. It appears, for both our health care system and society, that mental health services are cost-beneficial, at least under certain conditions. The conditions of treatment which should be reimbursed by insurance are, as I testified earlier, a complex matrix. Perhaps the best statement of this matrix has been assembled in a study conducted by the National Academy of Sciences, in conjunction with the National Institutes for Mental Health, for the 1978 President's Commission on Mental Health. It is a lengthy description, condition by condition, of what research literature found to be efficacious.

Given what I think is a reasonable conclusion from the research literature—that psychotherapy is more valuable that no therapy—is seems essential that the Medicare program establish a mechanism for integrating scientific information into its decision-making about reimbursement. As I described in my prepared testimony, the bill introduced by Senators Matsunaga and Inouye to establish a National Commission is one approach, but other approaches are possible. It is clear that in many cases we do not have the necessary scientific information. That does not, necessarily, mean that techniques are ineffective, just that we have not validated them as yet. If there is great concern about the efficacy of these techniques, it should result in better and more systematic funding or relevant research.

*Question 7.* What areas of present methods and theories of diagnosis and treatment of mental illness do you believe we should avoid covering at this time?

Dr. SAXE. As with the earlier question on what should be reimbursed, it is difficult to describe, specifically, what should not be reimbursed. I am not sure that any review of the scientific literature could answer such a question. My general recommendation would be to avoid covering untrained personnel and restrict reimbursement by length of treatment and type of treatment facility. The essential need is to develop a review mechnaism and a procedure whereby professional standards for treatment can be developed.

Chairman JACOBS. Thank you for your testimony.

Counsel, do you have any questions?

Dr. CARTER. I would like to know if you have any comments on the discussions we have had with earlier witnesses with respect to competition and whether opening up reimbursement to a number of mental health specialists would reduce prices.

Dr. SAXE. As a researcher, it is hard for me to comment directly because the appropriate studies have not been done. I think that is something that should be corrected. We need better research which would indicate what would happen if competition was opened up.

It is clear, however, from reviewing very carefully the data about the distribution—number and distribution of psychiatrists—that there are not sufficient numbers of psychiatrists and they are, perhaps, the most maldistributed specialty within medicine. The availability of care may be severely impaired by focusing on medical treatment and psychiatric care.

My sense is that the studies, particularly those you referred to earlier that have been done in HMO's about the offset costs of mental health care should in general be more widely applicable. If we could improve availability of mental health treatments, we should be able to achieve offsets and significant offsets in health care utilization costs. That should more than cover the costs of expanding treatment.

Dr. CARTER. Are you familiar at all with the notion of a team approach, understanding that in Michigan, in the Blue Cross/Blue Shield program, they had trouble with costs and they used what was referred to someone as a team approach.

Dr. SAXE. In fact, yes. I did some early work on that 5 or 6 years ago where we looked at developing interdisciplinary health teams. The idea was to organize a group of health professionals, not in the hierarchical model which is the one that results from the present reimbursement policy, but where each member of the team has more or less an equal say.

The critical component is that the team members come together and they discuss with one another a treatment plan. So, for some conditions, a physician may take the lead because primarily the problems are medical. In other cases, it may be a social worker or even a psychologist. The team approach has been used not only to deal with mental health problems, but to deal with general health care problems. For example, I can remember vividly the case of a patient who came to an internal medicine physician, essentially with complaints about stomachaches. All kinds of tests were run to try to identify the problem. By talking with the patient and then the internist talking with the social worker and other people on the team, it was identified early on in the diagnosis process that there were really other primary problems.

In the end, the patient received counseling and the symptoms disappeared. A considerable number of diagnostic tests were saved because of availability of these other people on the health team.

That is what I referred to before when I said that care must be coordinated. We have a provider-based system of health care and I think we need to move to one that is more of a system of health care.

Dr. CARTER. Thank you.

Chairman JACOBS. Thank you very much.

This concludes our hearings. We thank the witnesses who testified. If anybody would care to know, Mr. Schmidt wins, Ms. Potter is runner up.

[Whereupon, at 1:30 p.m., the hearing was adjourned, subject to the call of the Chair.]

[Submissions for the record follow:]

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FEDERAL TRADE COMMISSION,
*Washington, D.C., January 31, 1983.*

Hon. ANDY JACOBS, Jr.,
*Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Longworth House Office Building, Washington, D.C.*

DEAR MR. CHAIRMAN: I would like to thank you and the Subcommittee for the opportunity to comment on H.R. 6092.[1] This bill would amend titles XVIII and XIX of the Social Security Act to provide for the direct reimbursement of mental health specialists under the Medicare supplemental benefits program (Part B) and Medicaid programs for outpatient mental health care. The bill covers four groups of mental health professionals: psychiatrists, psychologists, clinical social workers, and psychiatric nurses.[2] Its enactment should promote competition and expand consumer choice in the mental health care field.

Currently, Medicare reimburses psychiatrists directly, but provides for the payment of non-physician mental health professionals only for care provided at the direction of a physician.[3] This restriction has the effect of furthering or supporting a dependent, non-competitive relationship between physicians and other mental health specialists and puts non-physician specialists engaged in independent practice at a competitive disadvantage. This bill would remove this disadvantage and expand consumer choice by broadening the range of independent mental health professionals whose services are available to consumers. The increased supply of alternative practitioners would also promote competition. Non-price competition, in such areas as the accessibility of care and innovation, as well as price competition should increase.

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[1] The views expressed in this letter are my own and do not necessarily represent the views of the other members of the Commission.

[2] The President's Commission on Mental Health identified these four groups as "core" mental health professionals and recommended direct reimbursement of all these professionals, President's Commission on Mental Health, Report to the President, vol. I at 29-30 (1978).

[3] The services of psychologists, clinical social workers and psychiatric nurses may currently be reimbursed if the services are: (1) performed "incident to" a physician's services, (2) performed in a physician's office, physician-directed clinic, mental health clinic, or hospital outpatient department, and (3) performed under the supervision of a physician. Psychologists may also receive reimbursement for physician-prescribed diagnostic services regardless of where the services are performed.

I am aware of the concern expressed by some that enactment of H.R. 6092 may adversely affect the quality of mental health care provided to the public. Strict quality of care issues are not within the Commission's traditional areas of expertise and therefore are not addressed in these comments. I would note only that the bill clearly and precisely limits direct reimbursement to the four named professional groups, and the Committee has had the advantage of extensive testimony from experts on the care that these specialists are trained to provide.

I am also aware that concern has been expressed that passage of this bill may cause increased costs to Medicare and Medicaid by encouraging overutilization of mental health services. Unfortunately, the available data are unclear on this issue. Increased competition should, however, have the effect of holding down price increases for covered services. In any event, total denial of direct reimbursement is not the only viable method to hold down costs. Alternative cost containment measures—such as a maximum flat rate payment per visit—could be incorporated into the bill which would ensure that the bill could still provide the benefits of increased competition and improved consumer choice without overburdening the Medicare and Medicaid systems. I will discuss the possible effects on competition of such cost containment measures further below.

Last year the FTC released a report by Lewin and Associates[4] which showed that dependent, non-competitive relationships between physicians and other health professionals impose significant costs on the delivery of health care. The referring physician's fee is an additional "middleman" cost imposed on both consumers and insurers. Limits on how non-physician health professionals can organize their practices and bill for their services make these fields less attractive career choices, and thereby discourage entry into independent practice. These limits in turn, harm consumers by reducing the supply of skilled mental health specialists.

The existing Medicare reimbursement policy perpetuates this situation and in effect discriminates against duly licensed professionals, retarding their development of independent practice. The states, through licensure and certification laws, have determined that many non-physician professionals are qualified to practice independently.[5] Medicare, because of its current bias favoring physician-psychiatrists frustrates the interest and apparent intent of most states to permit the independent practice of non-physician health care professionals.

The 1978 President's Commission on Mental Health (President's Commission) reported serious shortages of mental health care, and, in particular, an inadequate supply of psychiatrists' services in rural areas and in the inner cities.[6] The current reimbursement system may have the effect of perpetuating that situation; at least it does not promote the availability of care by non-physician mental health care providers to underserved areas.

The direct reimbursement of non-physician mental health care specialists, then, would clearly expand consumer choice and would also increase competition and promote innovation in responding to changing demand. Non-physician mental health specialists could choose either to work in direct competition with physicians or to continue existing cooperative relationships. The structure of their practice could be tailored to local market conditions. In other words, if the market were more competitive, providers would have added incentives to innovate and to be more responsive to consumers' needs.

I am certainly sensitive to the need to contain Medicare and Medicaid costs, as well as the cost of medical care generally. Thus I am aware of the concern that this bill might result in increased Medicare/Medicaid payouts. It is our experience and my belief that the increased competition which this bill would foster would help to hold the line on prices. According to a study by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), non-physician mental health professionals who provide services to the CHAMPUS population consistently charge less per hour than psychiatrists.[7] The availability of lower cost professionals in the market should put pressure on all professionals who provide similar services to hold down prices. Another recent study[8] found that state "freedom of choice" laws[9] promoted price competition between psychologists and psychiatrists. The study also found that in states with "freedom of choice" laws both psychiatrists and psychologists charged lower fees than in comparable states without such laws.

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[4] Lewin and Associates, Inc., "Competition Among Health Practitioners: The Influence of the Medical Profession on the Health Manpower Market," a report prepared for the Federal Trade Commission, V61–V68 (1981).

[5] All states either license or certify independent practice by psychologists. Twenty-two states license or certify clinical social workers at the independent clinical practice level.

[6] President's Commission on Mental Health, supra note 2, at vol. I at 36, and vol. II at 432–33.

[7] Office of the Civilian Health and Medical Program of the Uniformed Services, "User's Guide for Psychiatric Reports for Care Provided Under the CHAMPUS Program in Fiscal Year 1980," Table 12 (1982).

Some have argued that non-physician mental health professionals who engage in independent practice will attempt to raise their prices to levels comparable to those charged by psychiatrists and other physicians.[10] However, the study I just referred to provides some evidence that competitive pressures may be sufficient to check this possibility. In addition, incorporating an effective cost sharing device into the system would further inhibit this possibility by making consumers more sensitive to price. Substituting a maximum flat rate payment of perhaps $25 or $30 per visit for the current 50 percent copayment might go a long way toward accomplishing this goal. A flat rate would increase the cost sharing imposed on consumers who select higher priced professionals and thus make them more sensitive to price. Increased price sensitivity should encourage many consumers to substitute lower priced mental health services if it is appropriate.

In sum, direct reimbursement under Medicare and Medicaid to all four of the qualified mental health professionals identified in H.R. 6092 should increase competition in the delivery of mental health care and expand consumer choice. The current reimbursement system puts non-physician providers at a competitive disadvantage. Requiring a physician's supervision of the services of other state licensed mental health professionals in order to receive Medicare and Medicaid reimbursement tends to make these professionals dependent assistants rather than independent competitors. Direct reimbursement would put all qualified mental health specialists on a competitively equal footing. This change, by expanding choices available to patients, should increase the supply of available mental health professionals and encourage innovation in the delivery of mental health services.

Sincerely,

PATRICIA P. BAILEY, *Commissioner.*

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## STATEMENT OF THE ACTION COMMITTEE TO IMPLEMENT THE MENTAL HEALTH RECOMMENDATIONS OF THE 1981 WHITE HOUSE CONFERENCE ON AGING

The Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging is pleased to submit testimony in support of H.R. 6092—a bill introduced during the 97th Congress to expand Medicare and Medicaid coverage of services provided by key mental health professionals. The Action Committee, which is funded by the Retirement Research Foundation, is chaired by Arthur S. Flemming, former Secretary of Health, Education and Welfare and former Chair of the U.S. Civil Rights Commission. Other Action Committee members include: Bernice Neugarten, well-known psychologist and gerontologist from Northwestern University; Audrey Faulkner, a social worker and researcher from Rutgers University; Notre Dame University psychologist John Santos; civil rights activist and lawyer Frankie S. Freeman of St. Louis; and the geriatric psychiatrist Sanford Finkle of Chicago.

The Action Committee's major concern is directed toward issues of financing, organizing and delivering effective mental health services for older people. Foremost on the Action Committee agenda is Medicare reform to meet the mental health needs of older Americans. The issue implicit to this topic are aptly highlighted in the 1981 White House Conference on Aging recommendation #173 developed by the Delegate Committee (No. 6) on Options for Long Term Care.

"Whereas there is need for the Federal Government to give greater attention to the mental health needs of the elderly, therefore be it resolved that legislation be enacted that facilitates the following changes in the Medicare Program:

"1. A substantial increase in the elimination of the $250 per year ceiling on reimbursement for mental health services.

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[8] Frank, "Freedom of Choice Laws: Empirical Evidence of their Contribution to Competition in Mental Health Care Delivery," to be published in Health Policy Quarterly, Vol. 2, No. 2 (1982).

[9] Freedom of Choice Laws require private health insurers which provide coverage for psychiatrists' services to provide equivalent coverage for other qualified mental health professionals, such as psychologists.

[10] Proposed Amendments to Titles XVIII and XIX of the Social Security Act: Hearings on H.R. 6092 Before the Subcommittee on Health of the House Committee on Ways and Means, 97th Cong., 2d Sess. (Dec. 14, 1982) (statement of John Bowman, M.D., for the American Psychiatric Association).

"2. Replacement of the current 50-50 percent copayment procedures used for physical health care.

"3. There be coverage for all mental health services provided for the elderly. . . ."

Similar recommendations were developed by the White House Conference Delegate Committee (No. 5) on Health Care and Services and by the Mini Conference on the Mental Health of Older Americans conducted in November 1980 in preparation for the White House Conference. The Mini Conference, which was jointly convened by the American Nurses Association, the American Psychiatric Association, the American Psychological Association and the National Association of Social Workers, also developed resolutions calling for the following Medicare reforms:

"Medicare reimbursement for mental health services provided by Community Mental Health Centers, including those that are free standing, should be covered." And

"The services of all qualified mental health providers should be covered."

Certainly H.R. 6092 represents a major step toward the accomplishment of the latter objective. The Action Committee advocates, however, a more comprehensive series of reforms to implement the White House Conference and Mini Conference recommendations.

The mental health needs of older people are increasingly well-documented. Up to 25 percent of all Americans age 65 and over experience some form of emotional dysfunction, and as many as 30 percent experience depressive symptomatology. Nearly another 20 percent have alcohol related problems. While older adults comprise only slightly over 11 percent of the total population they account for nearly 20 percent of the nation's suicides. Evidence of emotional dysfunction increases dramatically among nursing home populations, where 50-75 percent of the residents show some form of behavioral and emotional disorder.

Despite myths to the contrary, most of the psychological conditions found in older adults are short-term and reversible. Chronic conditions associated with senility are experienced by only 5 percent of the over 65 population. The vast majority of the mental health conditions experienced by older people can be treated through relatively short-term therapy. Such treatment is, generally, most effectively delivered on an outpatient basis. Unfortunately, however, the Medicare program as currently constituted is largely an institutionally based program and does not provide older patients adequate access to community-based care.

Medicare is the largest purchaser of health care in the world, spending nearly $50 billion in 1982 alone. Yet, according to the Health Care Financing Administration, only 2.1 percent of total Medicare expenditures go toward mental health care. And, the majority of this small outlay is targeted toward inpatient, rather than community based care. Only 1.2 percent of Medicare beneficiaries spend any portion of their allowable reimbursement for outpatient mental health care. Data from the National Institute of Mental Health also reflect the limited delivery of outpatient mental health care, showing little more than 4 percent of all services provided by Community Mental Health Centers directed toward older clients. And, only 3 percent of mental health services by private practitioners in any setting are rendered to the elderly. Contrasted with these figures, National Institute of Mental Health data consistently show that 30 percent of the residents of public mental hospitals are age 65 and over. This remains true despite nearly a decade of deinstitutionalization.

As noted in the recommendations from the White House Conference on Aging and the Mini Conference on the Mental Health of Older Americans, there are a number of barriers to effective community-based mental health service delivery contained in the Medicare law as it now stands. The major impediments to outpatient care are: (1) The limitation of direct coverage only to physicians services and only to Community Mental Health Centers associated with general hospitals; (2) the $250 annual reimbursement limit for outpatient care; and (3) the 50-50 percent coinsurance requirement for mental health services.

In recognizing clinical psychologists, social workers and psychiatric nurses, H.R. 6092 is an important step toward expanding access to mental health services for older people. The current provisions in Medicare limiting direct payment to psychiatrists and other physicians clearly exacerbate the service shortage. As is noted in a recent General Accounting Office publication "The Elderly Remain in Need of Mental Services," only 4.5 percent of the full time equivalent staff in Community Mental Health Centers in 1979 were psychiatrists or other physicians.

The General Accounting Office report also notes that while many elderly are reluctant to seek services in mental health settings due to misperceptions of stigma associated with mental illness, older people can be treated in senior centers and other community-based social programs. Such social service agencies often employ non-physician mental health professionals, who are well qualified to provide on-site clinical and counseling services in a non-mental health environment. Thus, recognition of non-physician mental health providers will expand availability and access to professional mental health services for older people.

The bill does not, however, adjust current provisions prohibiting Medicare provider status for Community Mental Health Centers which are not associated with general hospitals. Thus approximately 90 percent of Community Mental Health Centers are not recognized. We urge that this situation be adjusted in amendments to H.R. 6092.

As noted above, H.R. 6092 is one important step toward more adequate provision of mental health services. The Action Committee, however, advocates that the other barriers mentioned above also be eliminated. Thus, we are calling for additional legislation in the following areas.

The $250 annual limit for outpatient care must be expanded up to $1,000 per year. This annual cap has remained unchanged since the beginning of the Medicare program. Given the well-documented inflationary increases in health related services over the last two decades, the $250 allowance now barely covers the cost of initial diagnosis. The Action Committee advocates that the limit be increased to $1,000 per year to allow 15-20 sessions of therapy. A number of studies indicate that therapy of such or shorter duration can effectively treat depression and other common conditions experienced by older people.

The coinsurance provision under the existing law, which requires beneficiaries to pay 50 percent of the cost of mental health care, must be changed. Such a provision is de facto inequitable, since the coinsurance rate for physical health care is only 20 percent. A recent Health Care Financing Administration study, "The Colorado Expanded Mental Health Benefits and Clinical Psychology Experiment," found that over 70 percent of the beneficiaries surveyed would like mental health services provided under the same conditions (including the 80-20 percent coinsurance formula) as physical health services. Aside from the equity principle, the coinsurance requirements impose an added financial impediment to older adults seeking mental health services. For instance, under the current law a beneficiary must pay $25-$30 for a $50-$60 session of therapy, while they would be required to pay only $10-$12 for comparable physical health treatment. Such a difference is significant for the older person living on a fixed income. The Action Committee, therefore, advocates the need for adjustment of the Medicare coinsurance rate to 80-20 percent for mental health services.

The Action Committee also wants to go on record in opposition to any proposed changes in the Medicare program which would increase cost sharing requirements for beneficiaries. Even with the current program, cost sharing requirements are prohibitive. In 1980 Medicare beneficiaries paid 45 percent of all health care expenditures, spending 19.1 percent of total income on health care. Such expenditure patterns regrettably show little improvement over the 20.4 percent of total income expended by older people for health care before the Medicare program was enacted.

While our remarks have been directed toward the Medicare program, we are pleased that H.R. 6092 provides comparable coverage of clinical services by psychologists, social workers and psychiatric nurses under Medicaid. Such recognition will assure nationally uniform access under Medicaid to services for those most in need, the medically indigent.

### CONCLUSION

In closing, we wish to note for the record that the most important aspect of this bill is the access it will provide older adults to a range of mental health services in a variety of settings. Such access is essential to enable older people to seek quality care in the environment of their choice. The Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging is pleased to have had the opportunity to address this key legislation. It is our hope that this bill will be reintroduced with the proposed changes outlined above at the earliest opportunity in the 98th Congress.

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## STATEMENT OF AETNA LIFE & CASUALTY

While we applaud the premise of providing more coverage under these programs, we feel that to do so now, when the programs are in such dire financial straits, would only tend to further exacerbate the programs' poor financial health.

Even though, under the provisions of this bill, the rate of reimbursement and the level of reimbursement for services rendered by mental health practitioners would non-physician mental health professionals, who are well qualified to provide on-site clinical and counseling services in a non-mental health environment. Thus, recognition of non-physician mental health providers will expand availability and access to professional mental health services for older people.

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The coinsurance provision under the existing law, which requires beneficiaries to pay 50 percent of the cost of mental health care, must be changed. Such a provision is de facto inequitable, since the coinsurance rate for physical health care is only 20 percent. A recent Health Care Financing Administration study, "The Colorado Expanded Mental Health Benefits and Clinical Psychology Experiment," found that over 70 percent of the beneficiaries surveyed would like mental health services provided under the same conditions (including the 80–20 percent coinsurance formula) as physical health services. Aside from the equity principle, the coinsurance requirements impose an added financial impediment to older adults seeking mental health services. For instance, under the current law a beneficiary must pay $25–$30 for a $50–$60 session of therapy, while they would be required to pay only $10–$12 for comparable physical health treatment. Such a difference is significant for the older person living on a fixed income. The Action Committee, therefore, advocates the need for adjustment of the Medicare coinsurance rate to 80–20 percent for mental health services.

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Even though, under the provisions of this bill, the rate of reimbursement and the level of reimbursement for services rendered by mental health practitioners would not be raised, I fear that a greater supply of mental health practitioners will create more demand for services. If patients do not seek out these newly qualified providers under the provisions of the bill, it is quite certain that the providers will seek out the patients.

Even though many mental health providers, such as the ones being considered for inclusion under the provisions of the bill, state that their charges for rendering services are less expensive than those charges made by medical doctors and psychiatrists, there is no evidence that these mental health "paraprofessionals" are in fact less expensive than M.D.s or psychiatrists for the services that they render. In fact, data gathered by the CHAMPUS program and the Government-Wide Indemnity Benefit Plan, one of the plans in the Federal Employees Health Benefits Program, shows that the charges for services rendered by qualified clinical psychologists, on average, are greater than the charges for services rendered by psychiatrists.

Over-utilization of services for the treatment of patients with mental health conditions is one of the problems that has had to be faced in large health insurance programs. CHAMPUS has had this problem. As the administrators of the Government-Wide Indemnity Benefit Plan, Aetna Life Insurance Company had a similar problem. We had to curtail over-utilization of services in the Plan by redesigning the benefits available to restrict outpatient care to 20 visits per calendar year in a mental health provider's office, or outpatient department of a hospital, or to 40 visits per calendar year if services were rendered in a qualified community mental health center. Our action was taken after I discovered that in 1973 12.4 percent of all benefits paid under the Indemnity Benefit Plan were paid for the treatment of mental health disorders and, more amazingly, were paid to 1 percent of the enrolled population of the Plan.

With the revised benefit structure in 1975, the Plan's rate of benefits paid for mental health care in that year and thereafter has returned to the norm that we have seen and continue to see under our regular group health plans for the treatment of mental health disorders.

We had to take the action to reduce benefits in the Indemnity Benefit Plan because we had no assistance from the mental health providers in having peer review mechanisms that would help overcome the overutilization of unnecessary mental health services. However, I am pleased to say that within the last two years both the American Psychiatric Association and the American Psychological Association have agreed, by contract, with the Aetna Life Insurance Company to provide peer review services for those instances of mental health care which appear to exceed the norms of care for particular diagnoses.

Inasmuch as peer review programs are not in place for social workers and psychiatric nurses, I think it would be prudent that such mechanisms be in place prior to their being included as reimbursable providers of care for Medicare and Medicaid.

With reference to the need for peer review mechanisms, I would remind you of the particular vulnerability of the aged to be the unwitting accomplices to overuse of services. While there may be a social need for them to receive counseling, we must recognize that in order to keep the cost of the Medicare and Medicaid programs from becoming even more prohibitive, benefits should only be paid for the provisions of services that are reasonably necessary for treatment of a medical or mental health condition.

In order that we may be able to gain some practical information relative to the usage and cost of services rendered by the "paraprofessionals" for which provisions are made in the bill, the experience of states which currently mandate coverage by private health insurance carriers for services rendered by psychiatric nurses, social workers and qualified clinical psychologists should be gathered and evaluated before national implementation of such coverage under the Medicare and Medicaid programs.

Thank you for giving us the opportunity to comment on this bill. If we may be of further assistance, please let us know.

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## STATEMENT ON BEHALF OF THE AMERICAN ART THERAPY ASSOCIATION, THE AMERICAN ASSOCIATION FOR MUSIC THERAPY, THE AMERICAN DANCE THERAPY ASSOCIATION, AND THE FEDERATION OF TRAINERS AND TRAINING PROGRAMS IN PSYCHODRAMA

This statement is submitted on behalf of The American Art Therapy Association, The American Association for Music Therapy, The American Dance Therapy Association and The Federation of Trainers and Training Programs in Psychodrama with respect to H.R. 6092, a bill to amend titles XVIII and XIX of the Social Security Act to provide more adequate coverage of the services of mental health specialists under the medicare supplemental benefits program and under medicaid programs.

These organizations propose an addition to section (bb) of the bill as follows:

New section (b).—The Term "art therapist" means an individual who (A) possesses a Masters Degree in Art Therapy and/or meets experience requirements established by a duly recognized national art therapy association; (B) is certified as a registered art therapist by a duly recognized national art therapy organization;

(7) The term "dance therapist" means an individual who (A) possesses a Masters Degree in dance therapy and/or meets the educational and experience requirements established by a duly recognized national dance therapy association; and (B) is certified as a registered dance therapist by a duly recognized national dance therapy organization;

(8) The term "music therapist" means an individual who (A) possesses a Bachelors or Masters Degree in music therapy and/or meets experience requirements established by a duly recognized national music therapy organization and (B) is certified as a certified or registered music therapist by a duly recognized national music therapy organization;

(9) The term "psychodramatist" means an individual who (A) possesses a Masters Degree and the relevant experience and specialized training established by a recognized national psychodrama association and (B) is certified as a psychodramatist by a duly recognized national psychodrama association.

Inclusion of art therapy, music therapy, dance therapy and psychodrama is essential if the full range of needed services is to be available to medicare and medicaid recipients. Each of the services is presently included under the Medicare Mental Health Demonstration Project, supported jointly by NIMH and HCFA.

Finally, these firms and service providers—art therapists, dance therapists, music therapists and psychodramatists were singled out for special attention in the Senate Report to the Mental Health Systems Act as providing especially significant and worthwhile services.

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## STATEMENT OF THE AMERICAN HEALTH CARE ASSOCIATION

### INTRODUCTION

The American Health Care Association is the nation's largest federation of long term care facilities. Over 8,000 member skilled nursing, intermediate care and residential care facilities care for over 750,000 frail, disabled or chronically ill persons of all ages.

AHCA is submitting these comments for the Committee to consider as it deliberates the merits of H.R. 3921, concerning Medicare coverage of personal emergency response systems and H.R. 6092, concerning increasing coverage for mental health specialists. Our knowledge of the needs of the elderly and of long term care enable us to provide you with remarks on the impact these proposals would have on the long term care consumers and providers.

### H.R. 3921

H.R. 3921 would provide coverage of personal emergency response systems under Medicare, Part B. Currently these services are not provided under Medicare.

### AHCA POSITION AND RECOMMENDATIONS

AHCA supports personal emergency response systems as a part of the continuum of long term care services. Many AHCA members who are involved with multilevels of long term care services provide personal emergency response systems in some levels. Apartments for the elderly or chronically ill or other residential type settings often include personal emergency response services for the elderly who do not require nursing or medical services yet who opt for or require a protective environment. For the most part, people in these settings are independent but choose to purchase the personal emergency services as an added assurance they will receive needed services.

While AHCA supports the concept of personal emergency response systems, we question whether the systems have been fully tested for their effectiveness and whether their cost benefit ratio has been assessed. We suggest that further demonstrations to thoroughly test the system are necessary before a final conclusion on the impact of these programs can be made.

On reviewing the Executive Summary of the National Center for Health Services Research funded study on the Effects of an Emergency Alarm and Response System for the Aged, we find many factors which we believe should have been included in the study but were not. For example:

The study does not mention what long term care services were consumed by the Lifeline users. While the number of nursing home days used by Lifeline participants may be less than for those in the control group, a study of the noninstitutional services consumed by Lifeline users is necessary to accurately determine the impact on long term care services. It is possible that Lifeline users consume fewer nursing home days, but a greater number of costly community-based services.

While the study concludes the Lifeline users utilized nursing homes less than nonusers, it does not note whether or not any of those in the study were at risk of institutionalization prior to using Lifeline.

The study does not mention the cost of the installation of the equipment either in the home or the Central Station. This is necessary to determine the impact on the Medicare funds.

The study does not attempt to estimate how many users would have dialed 911 or other emergency numbers for emergency response rather than signal the Lifeline Central Station. Since 911 was by far the most active responder called upon by the Central Station operator, Lifeline could be just another means for attaining the same result.

The Quality of Life Analysis concludes that those Lifeline users not "socially isolated" were more likely to extend themselves and experienced less anxiety about living alone. We question whether these results can be attributed to Lifeline or can be explained by the individuals not being socially isolated.

The study found that there were no significant differences in the use of acute hospitalization between the control group and the experimental group. Since acute hospitalization is required for Medicare home and nursing home benefits, one questions whether a Medicare beneficiary who has been hospitalized would choose Lifeline over the home care or skilled nursing care he/she is eligible for after hospitalization.

We caution against interpreting the reduced use of nursing homes in this study to mean a cost savings to Medicare. The Medicare benefit for nursing homes is restricted to coverage for skilled care services. Currently, Medicare benefits cover less than two percent of the total nursing home payments. Eighty percent of our nursing home beds are intermediate care beds and are available for those who do not require skilled care. If the use of the personal emergency response systems reduces the use of nursing home services, it cannot be assumed that they would reduce the use of Medicare covered stays and result in a cost savings to Medicare.

AHCA believes personal emergency response systems can be beneficial and in some cases cost effective. However, we believe there is a need to study the systems further to pinpoint the exact circumstances under which the personal emergency response systems can be cost effective, particularly before a Medicare benefit is created. Among the factors we believe should be included in a demonstration study are:

A study of how personal emergency response systems are utilized in conjunction with other long term care services. Do personal emergency response systems substitute for other long term care services or are they used as add-on services.

The costs of personal emergency response systems including installation and maintenance. The study should include the costs and impact of several kinds of personal emergency response systems (including the use of cordless phones).

The study should include a heterogeneous experimental group. Since Medicare beneficiaries vary widely in age and other characteristics, the study should include a sample of the beneficiaries.

The study should determine who would benefit most from use of the system: Should those elderly who are at risk of institutionalization, or those whose medical history indicates a likelihood of an emergency or all Medicare beneficiaries be eligible for the benefit? Estimates of utilization by the different groups should be made.

Once this information has been collected, the impact of personal emergency resonse systems can be determined and the merits of including it in a package of Medicare benefits can be debated knowledgeably.

AHCA cautions against avoiding a technology trap which may exist in H.R. 3921. With rapid advances in telecommunications, micro-electronics and alarm systems, a program or system should not be limited to existing telephone lines as proposed in H.R. 3921. For example, cordless phones and two-way cable systems should be considered.

AHCA recommends that any expansion of Medicare benefits should be consistent with other Medicare benefits. Other noninstitutional services require the beneficiary to be "homebound." Noninstitutional, nonmedical services under Medicare are allowed only if incidental to Medicare services. Home health aide services are provided only if incidental to home health services. Since personal emergency response systems are neither medical nor acute care, perhaps coverage of the systems should be provided as incidental to post-hospital or SNF, hospice or home health care. If provided, AHCA suggests they be delivered only by a primary Medicare provider such as a hospital, SNF, HHA or hospice. There is no need for a new provider category, particularly when the new provider does not supply health care services.

### H.R. 6092

H.R. 6092 would amend Medicare and Medicaid to provide direct reimbursement for the services of mental health specialists, including clinical social workers, clinical psychologists and psychiatric nurse specialists.

Under current law, reimbursement to mental health practitioners other than physicians is allowed only when the services are incidental to physician's services or if the practitioner is an employee of a hospital or physician-directed clinic.

### AHCA POSITION AND RECOMMENDATIONS

AHCA supports the intent of H.R. 6092, to increase mental health services. However, as advocates of long term care residents, we cannot support any program which will not improve the delivery of mental health services for residents of long term care facilities. Previous programs to increase services have ignored long term care residents. Community-based programs do not extend to the institutionalized and there is no mechanism for the facility to provide services. Any proposals to increase mental health services must assure that long term care residents have access to services.

AHCA supports Medicare reimbursement for nonphysician health professionals. However, we believe such services should be covered only when under the direction, management or referral of a physician. This is necessary to assure that the patient's total needs are assessed and that the mental health services are an integral part of the individual's overall plan of care.

Since the elderly and long term care residents have special mental health needs, AHCA recommends skilled nursing facilities be included among the certified locations for the delivery of mental health services. Currently, hospitals, physician's offices, and physician-directed clinics are eligible for this reimbursement. As certified Medicare providers, SNFs are already considered appropriate sites for the delivery of Medicare services. The addition of mental health services would enable the facility to assure that the total needs of the residents will be met.

A recent GAO report notes that long term care facilities are not equipped to provide mental health services and that there is little incentive to provide them. Many of the reasons behind this criticism are related to discriminatory federal policies and the ineffectiveness of the current mental health programs.

If long term care facilities are to continue to be asked to care for the chronically mental ill as deinstitutionalization, transfers from state hospitals, and closings of substandard boarding homes and old hotels continue, the facilities must be enabled to provide or arrange for competent psychiatric services. Access to services outside the facility and reimbursement for services delivered by the facility would be a major step toward meeting the needs of the mentally ill. Long term care facilities must have the support of community services such as community mental health centers, professional outreach programs and consultants to provide professional services. Provider agreements between institutional and noninstitutional services would enable both programs to work together to meet the total needs of the individuals.

AHCA urges your serious consideration of our comments made here today.

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## STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association takes this opportunity to submit this statement for the December 14, 1982 hearing record on H.R. 6092. The AMA opposes this bill as it would needlessly expand the Medicare and Medicaid programs while failing to assure the maintenance of adequate health care coverage for program beneficiaries.

H.R. 6092 would expand Medicare and Medicaid covered benefits to include direct payment for the services of "mental health specialists" by incorporating this new term within the existing definition of "physician." The bill defines this term to include clinical psychologists, clinical social workers, psychiatric nurse specialists, and psychiatrists. Individuals incorporated within this definition must minimally meet state licensure or certification requirements. In addition, a "clinical psychologist" must either hold a doctorate degree in psychology or have been licensed or certified prior to 1978 with a master's degree, and he or she must have completed at least two years of supervised experience in health services with one year of that being post-degree. A "clinical social worker" must possess at least a master's degree in social work with two years of post-degree supervised clinical social work experience. A "pyschiatric nurse specialist" must hold at least a master's degree in psychiatric nursing or in a "related field," and be certified by a "recognized national professional nurse organization." The bill defines a "psychiatrist" as a physician who is board certified or who has completed a minimum three-year approved graduate medical training program in psychiatry.

### ADEQUACY OF CARE

The American Medical Association opposes H.R. 6092 as being both unnecessary and inappropriate. Passage of this legislation would allow individuals lacking medical skill and training to serve as the first entry point to care for Medicare and Medicaid beneficiaries with mental or emotional disorders. While individuals trained as "mental health specialists" may perform psychoanalytical functions, all but the physician, frequently a psychiatrist, lack the expertise to identify or treat a mental health problem that is caused by a medical condition. In addition, the medical doctor is the only individual listed among those that the bill would classify as "mental health specialists" who is qualified by training and law to treat a medical condition that is either co-existing or causing the mental or emotional problem.

Under the Medicare program, the physician acts as the entry point to mental health care. In this manner, the program incorporates a check to assure that program beneficiaries seeking care for mental or emotional disorders will first seek that care from physicians. Such physicians can treat not only the emotional or mental disorder, they are also fully qualified to diagnose and treat physical ailments that may actually underlie or be associated with the emotional or mental disorder. Therefore, it is appropriate that the physician should fill the role of initiator of care for emotional or mental disorders. This is especially true in light of the fact that treatment for mental or emotional disorders may not be limited to psychotherapy that may be furnished by a non-M.D. mental health specialist,

### PARITY OF BENEFITS

The American Medical Association is equally concerned that this legislation ignores the fact that the Medicare program does not provide parity of benefits between those covered for physical problems and those covered for mental or emotional disorders. Section 1833(C) of the Social Security Act limits outpatient coverage for mental, psychoneurotic and personality disorders to a maximum annual amount of $312.50 (less deductible), or 62.5 percent of such expenses.

The limitation for outpatient mental or emotional disorders discriminates against the program beneficiary suffering from mental or emotional disorders. A coverage differentiation between mental or emotional disorders and physical disorders is inappropriate, and H.R. 6092 would continue this discrimination.

### INAPPROPRIATE BENEFIT EXTENSION

H.R. 6092 would amend the Social Security Act by extending Medicare and Medicaid medical services to cover essentially social services provided by non-physicians. This extension would stretch already limited benefit dollars and further dilute resources that are needed for the provision of necessary medical care. Coverage for the services of "mental health specialists" who are unable to make medical determinations within the scope of programs established to preserve the health status of Medicare and Medicaid beneficiaries is inappropriate and should not be implemented. The bill would add further confusion in the Medicare and Medicaid programs by extending the definition of "physician" to include non-physician "mental health specialists."

This expansion of "physician" would categorize individuals who are not qualified by state law to provide medical services in the same classification under Medicare and Medicaid as individuals holding degrees from medical and osteopathic colleges and licensed by states to practice medicine. Such an extension would be clearly inappropriate as there is a significant difference between the qualifications of medical and ostepathic physicians and the range of services they can furnish and "clinical social workers," "psychiatric nurse specialists" and "clincial psychologists" who could be qualified to deliver Medicare and Medicaid reimbursable services as "mental health specialists." Federal law should not interfere with the state jurisdiction in defining the practice and function of a "physician."

### CONCLUSION

The American Medical Association is now embarking on a program, the Health Policy Agenda for the American People, that is designed to take an in-depth look at how health care is delivered in this country and how it should be delivered in the future to asure the maintenance of the high quality of care expected by the American people. An element of this study will be an examination of mental health care needs. We expect that this information will be of significant benefit to the committee in its deliberations in the future on legislation such as H.R. 6092. In addition, we note that the federal government is involved in ongoing studies that are designed to determine the effectiveness of authorizing non-physician mental health personnel in treating mental or emotional disorders.

For the foregoing reasons, the American Medical Association recommends that H.R. 6092 not be enacted.

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## STATEMENT OF THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, INC.

The American Orthopsychiatric Association is a national, professional, educational organization of close to 10,000 members from the behavioral, medical and social sciences. Its major goal is to achieve a collaborative approach to professional practice, policy and knowledge relating to mental health and human development through a multidisciplinary perspective.

The Board of Directors of the American Orthopsychiatric Association welcomes this opportunity to respond to the proposal of HR 6092 to introduce the concept of Medicare and Medicaid reimbursement on a federal level for mental health specialists. The proposal provides careful definition of what constitutes an adequately qualified mental health specialist and would result in widening the choices of resource providers for Medicare and Medicaid recipients. The present limitation to a physician (with no requirements as to mental health experience) as the sole provider of mental health services raises serious question. At stake is how to provide the most adequate services for the large number of underserved people within Medicare's and Medicaid's funding limitations and community resources.

Each of the professions concerned has presented its position on the proposed change in HR 6092 plus significant supporting data in most of their presentations. The American Orthopsychiatric Association is not guild-oriented but rather problem-oriented so that our discussion is directed to the basic issue of providing care.

Determination of the personnel necessary to provide necessary services was faced by our Association shortly after its founding. It was founded in 1923 by nine young phychiatrists (among them Karl Menninger, David Levy, William Healy) concerned with the study and treatment of behavior in the community. They saw the individual as a composite of physical, emotional and social forces interacting with the world in which he or she lives. Their emphasis was on "deformity, not disease" and on "the correction and prevention of deformity."

By 1925, only two years later, the Founding Fathers agreed that to achieve their goal, they needed input from psychology, social work, education and other related professions. Increasingly over the years, knowledge from all of the helping professions has been found to be essential to develop an understanding of the services that are useful to people in need, and provide the services that are most responsive to that need. Inherent in this conclusion is the basic concept that to provide adequate service for people and particularly for the underserved, there should be a way of providing the collaboration and contribution of various mental health professions.

The President's Commission on Mental Health, in its 1978 report, stressed that funding mechanisms should be based on "appropriateness of care, not on the discipline of the provider." Congress, in developing Medicare and Medicaid law, also guaranteed "freedom of choice in selection of service providers."

Less than 3 percent of the Medicare and Medicaid budget is used for mental health services although it is estimated that 15 percent of the population need such services. Particularly underserved are those in rural areas, in small towns, the urban poor, the elderly, children, and the racial and ethnic minority groups.

A major mental health personnel problem facing us at this time is the mal-distribution of that personnel. There are proportionately fewer mental health practitioners in the rural areas, smaller towns and poor urban communities.

The Commission's 1978 report notes that "payment for services rendered by qualified providers, regardless of discipline, with review of the quality of services, would do much to solve the utilization problem." It adds that "the Health Professionals' Educational Assistance Act (PL 94-484) should be amended to specifically include psychologists and social workers among 'the health professions'. And that, psychiatrists, clinical psychologists, social workers and psychiatric/mental health nurses provided most of the services labelled 'mental health' in 1955."

Older Americans do not have sufficient access to services or personnel trained to respond to the special mental health needs characteristic of their age. There are more mental health problems for the population over 67 than in the general population. (Twenty-seven percent of the aging have problems; only 2 percent are seen in private psychiatric care for the elderly.)

The President's Commission on Mental Health reported concerns about the emphasis in Medicare and Medicaid on the use of the psychiatrist (they did not refer to the use of a physician without mental health training). There are over 27,000 psychiatrists with a ratio of 12.4 to 10,000 in the population. One half are in private practice, the other half in public service. Psychiatry has fewer minority practitioners. Also, few practice child psychiatry with about 2,800 in the U.S. in 1978, while children were 40 percent of the population. Only a handful of psychiatrists specialize in the psychiatric problems of aging (by the year 2000, 25 percent of the population will be over 65).

The 1978 President's Commission report sees "psychiatry as the medical specialty which deals with the diagnosis and treatment of mental disorder. As a physician, the psychiatrist possesses special skills in comprehensive evaluation, including the organic causes of mental illness and the psychiatric complications of organic disease, the management of psychiatric emergencies, the competent use of psychoactive medications, and the use of other physical treatments for mental illness." At time time, we have no definite knowledge as to the number of individuals with mental health problems where the basic difficulty stems from organic factors. Organicity is still an unresolved question as to its extensiveness as a factor in emotional disturbance.

In 1976, there were over 42,000 psychologists in the American Psychological Association, and approximately 70,000 with Masters and Doctors levels in psychology in the country. The minority psychologists at that time were less than 1 percent. One quarter were in full-time private practice; 57 percent did some private practice.

In general, mental health personnel, especially social workers, carry on many of their activities within other human service systems, thus providing linkages in these systems. Social work is described as "a profession that provides a variety of social and human services for the purposes of encouraging and sustaining optimal social functioning in individuals, families, groups and the community. They have more minority members than do either the psychiatrists or the psychologists." The report of the President's Commission stresses that the strength of the social worker lies in "the integrating work they do with clients, families and resources in the community." It also states that "social workers get more training in cross-cultural value systems than do either the psychiatrists or the psychologists." Social workers provide as much individual psychotherapy as any other mental health professional. A few are in full-time private practice; 40 percent of the social work professionals have some form of part-time private practice.

The American Nursing Association, since 1975, certifies a separate division of psychiatric/mental health nurses. In 1978, their number was approximately 29,000 so certified, of which 4 percent were Black and 3 percent were from other races.

It is interesting to note that the Commission report states "Medicaid favors institutional care. Almost 7 percent of mental health care reimbursed under Medicaid in the fiscal year 1977 was for inpatient services. Over one half of all Medicaid funds expended for mental health services went to nursing homes." Similarly, "the greater proportion of psychiatrists were reported as found in inpatient (private and public) rather than in outpatient facilities. Also, they occupy most of the important leadership and administrative positions in public inpatient services. They typically average less than one half of their time in direct patient care." Nearly 90 percent of the psychiatrists have some form of private practice, primarily for upper socioeconomic class patients.

A critical question that merits exploration for mental health care is treatment services that focus on building health and function support systems rather than stress on psychopathology. Also, is the community's provision of care focused on outpatient services as against the predominance of inpatient care. With doctors providing service, the tendency is to focus on psychopathology and on the institutional placement of many of the individuals on Medicare and Medicaid who apply for service. The currently accepted principle in the mental health field is to provide the least restrictive service for individuals seeking help. The least restrictive service usually results in maintaining a life in the community to the degree that this is possible. Steps include the use of a variety of programs, i.e. housekeeping services, "food on wheels", visiting programs to the aged, day care programs, etc. These services tend to be a larger part of the armentarium of psychologists, social workers and psychiatric/mental health nurses than of psychiatrists.

The quality and nature of training for mental health personnel is also a critical issue for staff serving Medicare and Medicaid patients. It is important that these staff have training and experience with the elderly, children, minorities and the poor, plus knowledge not only of community resources and support services but also of techniques for using them in the interest of the patient.

Furthermore, "good treatment practice" facilitates the use of consultation and sharing of information, knowledge and skills. This is especially essential where there may be question as to psychological, physiological or educational problems in the treatment of the individual.

Another issue is the failure of individuals to use services. Underuse of services has been seen as related to both accessibility of service and possible stigma associated with psychiatric services. "Stigma," it was noted by the President's report, is the real barrier to seeking care. In public hearings held around the country, members of the President's Commission on Mental Health heard about the problems of patients and families. Consistently, one problem came through clearly and that was the stigma that not only haunts lives when they are ill, but also after recovery.

Yet another question is that of the impact of mental health services on the use and cost of other health care programs.

The statements of representatives of specific professions have included studies pointing to the conclusion that mental health care that is readily accessible and with action to reduce stigma asociated with it, results in more efficient and productive use of other health services. (See attached addenda for studies reported) ADAMHA estimates that one third of all health care costs can be attributed to emotional problems.

If we are to make mental health services to Medicare and Medicaid patients available on a sound basis, it is crucial that we broaden, as is proposed in HR 6092, the choice for these patients by including reimbursement for the additional mental health professionals defined and proposed. Further, we need to assure service within the least restrictive alternative to make services readily accessible and as free of stigma as is possible. The latter appears to be best achieved by a focus on health and function rather than on psychopathology. The current available information indicates that individuals receiving adequate mental health care are less likely to over-use other health services and thus enable the provision of more cost effective service.

## ADDENDA

Resource for Data:

Task Panel Reports, Submitted to the President's Commission on Mental Health—Vol. I 1978; Vol. II 1978; and Vol. IV 1978.

Joseph B. Collins, Administrator, Mental Health Services, Health Insurance Plan of Greater New York to Pat B. Wellons, President, Kentucky Society for Clinical Social Workers, June 23, 1981.

Ben Evans, Director, American Postal Workers Union, AFL-CIO to Pat B. Wellons, President, Kentucky Society for Clinical Social Workers.

(Copies from Task Panel Reports of President's Commission on Mental Health—Vol. II 1978.)

Successful mental health services have resulted in improvements in work performance, reductions in morbidity, fewer absences from work duties, and reduction in staff turnover. In some instances, the improvements in production efficiencies have offset the costs of these mental health services.

In other instances, the use of more appropriate mental health services has reduced the need for other health services and so reduced cost. In instances where care in outpatient settings is preferable to resident care, there are savings in health care costs. Preventive services and other means of detection and early intervention reduce the need for more expensive crisis care or longer term care as inpatients in resident institutions. Good economic policy demands that the financing mechanisms encourage the use of less expensive modes of treatment when these are more therapeutic.

The panel urged that the highest public priority involved overcoming the barriers to access to mental health services for the poor—particularly children and the elderly. These people seldom have and cannot afford to purchase adequate mental health coverage. For persons with limited mental health coverage the kind of coverage provided may also be creating difficulty.

A number of limited studies are underway in the business community regarding the cost of, and the relationship between, emotional and mental distress and productivity. Factors being considered are performance on the job; absenteeism; employee relations; labor relations; hospital, medical, and surgical cost; workman's compensation; and turnover rates. The trend toward expansion of mental health coverage, coupled with an increasing number of "troubled employee" or "broad brush" counseling services, indicates increasing business and union awareness of the impact or interference of employees' mental distress on their daily lives. While these early results may not have the validity of clinical trials, they are nonetheless indicative of the efficacy of mental health intervention and of the cost to the general economy when emotional problems are not treated.

The Equitable Life Assurance Society's Emotional Health Program includes conventional insight-oriented and behavioral modification psychotherapy and Stress Management Training. The Stress Management Training program treats employees with stress-related disorders such as general anxiety, tension, and migraine headaches. Before treatment the "average hourly interference effect" of stress was estimated by the employees at 25 percent. After treatment this measure dramatically decreased to 3 percent. Based on early findings, Equitable estimates that for every $1.00 of treatment cost there was a $3 return in recovered productivity (Manuso 1978).

The INSIGHT Program at Kennecott Copper Company is a 24-hour-a-day, 7-day-a-week counseling and referral program available to the 32,000 employees and dependents. The comparative results of the INSIGHT Program of 150 participants and 150 nonparticipants for a 1-year period are impressive. Hospital, medical, and surgical costs for participants decreased 55.4 percent compared with a 1.5 percent increase for nonparticipants; participant absenteeism decreased 52 percent compared with a 6.3 percent increase for nonparticipants; and nonoccupational Accident and Sickness Insurance costs decreased 74.6 percent compared with a 38.5 percent decrease for nonparticipants (PA International Management Consultants 1973, p. 17; Jones 1978). Estimated savings per participant based on "before" and "after" figures amounted to $905 per man annually (Hospital, Medical, and Surgical savings, $620; Absenteeism, $51; and Nonoccupational Accident and Sickness Insurance savings, $233). Conservative projections by Kennecott based on 6.25 percent of the work force participating in the counseling program would amount to savings in excess of $1 million for a work force of 20,000 employees (PA International Management Consultants 1973, pp. 18–19). Other companies contacted concurred that the employee assistance programs were valuable to the company, the employees, and to productivity. These companies, which had either not costed out savings or could not release their data, included International Paper Company, CNA Insurance, Polaroid, and U.S. Steel.

Experts in this area, including Dr. Shelly Akabas of the School of Social work of Columbia University, Carvel Taylor of CNA Insurance and the University of Chicago School of Social Work, James Manuso of the Equitable Life Assurance Society, and Otto Jones of Human Affairs, Inc., agreed with members of the panel that the availability of care to most workers and their families and their ability to finance such care are generally overstated. By and large, workers and their families do not have access to adequate mental health care and the imposition of significant cost-sharing requirements creates serious barriers against their obtaining such care. This is not to ignore the greater stress that accompanies unemployment, or the legitimate concerns about negative potential of such programs. Nonetheless:

"In hundreds of workplaces throughout the country, mental health service delivery systems have been put in place. Some are sponsored by trade unions, others by corporate management and others by a joint effort of labor and industry. There are many advantages to such services, perhaps foremost is their preventive character. It is relatively easy to identify a person at the workplace who is in need of some kind of assistance, to reach him early and to connect him with care (Akabas 1977)."

These are highly innovative service delivery programs. They have exciting potential for deliverying effective, efficient, quality care without government funding. At the very least, the programs mentioned above are indicative of what the costs can be when mental health services are not provided.

## BENEFITS TO THE HEALTH ECONOMY

Two aspects of the relationship between mental health costs and the health economy were discussed:

1. The prevalence of mental health problems in the general health care system and
2. The effect of mental health care on the utilization of general medical services.

In the first instance, a significant number of mental or emotional problems are currently cared for in the general health system, and to some degree are financed through general health reimbursement. Studies indicate as many as 15 percent of the patients seen in general medical settings may be diagnosed as having a psychiatric or emotional disorder (DHEW/NIMH Draft Report 1976, p. 27). Significantly higher rates of psychiatric disorders have been found for specialized medical settings such as hospital-based clinics and emergency rooms (DHEW/NIMH Draft Report 1976, p. 27). Cummings estimates that "60 percent or more of the physician visits are made by patients who demonstrate an emotional, rather than an organic etiology for their physical symptoms" (*American Psychologist* Sept. 1977, p. 711). The classification of these conditions as a somatic problem results in part from the stigma attached to mental health conditions and the limitations on reimbursement for mental health services, and in part from the difficulties in detecting and treating the mental conditions underlying physical symptoms.

Available evidence supports the view that funding of somatic medical care currently pays for a significant amount of care for emotional or mental problems, even though they are not defined or reported as such. In such situations where the provider is not specifically trained to provide mental health services, the quality of care may be questioned and expenditures for such care may be misdirected and of questionable benefit.

The second area deals with the substitution effect on general medical utilization when mental health services are provided. Several widely quoted papers have reported results of longitudinal, controlled studies of nonpsychiatric services before and after psychiatric intervention. They are briefly described here.

The Kaiser Foundation Plan in Northern California studied a randomly selected group of psychiatric patients who received either a single session, a moderate series of sessions, or long-term therapy (Follette and Cummings 1967; Cummings and Follette 1968). Utilization of all plan services for the year prior to psychiatric intervention was compared to the utilization for the next 5 years. In each subgroup hospital utilization immediately decreased by over 50 percent. Outpatient visits, including psychiatric visits, decreased sharply for those receiving either a single or moderate number of sessions; by the end of 5 years, their utilization was less than half of what it had been prior to intervention (Jones 1977). There was a significant decline (from 11.4 to 4.4 visits) over 6 years in medical utilization for the group receiving psychotherapy compared with a slight increase (from 11.4 to 12.9 visits) in medical therapy compared with a slight increase (from 11.4 to 12.9 visits) in medical utilization by the control group. This decline was apparant whether the measure used was the number of outpatient visits, days of hospitalization, or a combination of these with psychiatric services (Lewin and Associates 1978).

In a similar study; Group Association of Washington, D.C., found that in the year following psychiatric referral, the number of visits for physician services and X-ray and laboratory procedures both decreased by approximately 30 percent (Goldberg, Krantz, Locke 1970).

Blue Cross of Western Pennsylvania compared the medical/surgical utilization of 169 subscribers who used an outpatient psychotherapy benefit in community mental health centers with that of a control group (Jameson, Shuman, Young 1976). Medical/surgical utilization was significantly reduced for the group who used the psychiatric benefits. Medical/surgical inpatient days and outpatient visits per month decreased by more than 54 percent. The monthly cost per patient in the study group for medical services dropped by $9.41 (from $16.47 to $7.06)—well below the average per-patient cost for the control group. The reduced medical/surgical utilization following outpatient psychotherapy benefits was found to be independent of age, sex, or employment level (Levin and Associates 1978).

These reports of positive indications of health economic benefits achieved through mental health intervention are provocative. Each study individually must be interpreted conservatively. But, as a group, this research is striking. Research from health maintenance organizations (HMO's), from industrial programs, and from regular health insurance plans suggests that providing outpatient mental services can reduce overall health services utilization and overall health costs.

The evidence strongly suggests that the cost of including or expanding mental health coverage would be partially or wholly offset by decreasing use of general medical services. Current data do not allow a firm estimate of the net effect of including mental health care, but "these studies suggest that mental health treatment may reduce other health service utilization and lead to more appropriate utilization and improved quality of care" (DHEW/NIMH Draft Report 1976, p. 67).

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BAPTIST MEDICAL CENTERS,
*Birmingham, Ala., January 7, 1983.*

Hon. ANDREW JACOBS,
*Chairman, Health Subcommittee, House Ways and Means,*
*U.S. House of Representatives, Washington, D.C.*

DEAR SIR: I want to lend my support for the passage of H.R. 3921. This bill which, if passed, will make emergency response systems reimbursable under Medicare and will be tremendously beneficial to many elderly and handicapped people who live independently and alone.

Such systems have been demonstrated to be cost beneficial by keeping people in their homes longer and out of hospitals and nursing homes.

The Federal Government has complained about the costs of hospitals and nursing home care for years. This is an opportunity to do something about them. In my opinion, it's time to put up or shut up.

Sincerely,

DR. ROBERT G. WILKERSON,
*Vice President—Administration,*
*Baptist Medical Center—Princeton.*

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BLUE CROSS AND BLUE SHIELD ASSOCIATION,
*Washington, D.C., January 18, 1983.*

Hon. ANDREW JACOBS,
*Chairman, Subcommittee on Health of the Committee on Ways and Means,*
*U.S. House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: The Blue Cross and Blue Shield Association appreciates the opportunity to submit our views for the record on H.R. 6092 and H.R. 3921.

One of the proposals H.R. 6092, would provide coverage for direct reimbursement for services provided by "mental health professionals", including clinical psychologists, clinical social workers, psychiatric nurse specialists, and psychiatrists. The other bill, H.R. 3921, would provide coverage for personal emergency response services. Benefits would be expanded to cover the equipment for signaling an emergency in the home, any necessary servicing of the equipment and the services related to monitoring the system.

Like the federal government, Blue Cross and Blue Shield Plans must continually reevaluate the scope of covered benefits and assess whether those benefits need to be expanded to meet the health care needs of our subscribers. And, like the government, we must weigh a number of factors in deciding to cover new benefits: the potential cost of the service, the likely utilization, and the contribution the benefit will make to the good health of the subscriber relative to other covered benefits.

During these times of rapidly increasing health care costs we—just like the government—have to hold any proposed new benefits against tougher yardstick. In our case, we have to ask whether the subscriber or the employer will be willing to pay a higher premium for the new benefits or offset its cost by cutting other benefits. Realistically, the government also must ask whether any new benefits are potentially so valuable that consideration should be given to robbing Peter to pay Paul—that is, offsetting the cost by either reducing payment for already covered services or increasing beneficiary cost sharing.

The Congress has now gone through three extremely painful budget cutting exercises: the Reconciliation bills of 1980 and 1981 and the recently enacted Tax Equity and Fiscal Responsibility Act of 1982. Under all of these bills, legislators have had to make very hard decisions about how to reduce the rate of increase in Medicare expenditures. Some of the savings have come from changes which will truly improve the efficiency of the program. Much of the savings, however, were made by arbitrarily reducing payment for covered services and, even more painful, increasing the out-of-pocket payments for the aged. The changes in beneficiary cost sharing in the 1981 budget bill, for example, resulted in about a twenty-five percent increase in out-of-pocket costs to beneficiaries.

Given the fiscal constraints on the program, we do not believe the time is appropriate for the Congress to consider adding new benefits to the program. We are concerned that during the next round of budget cuts—which will begin in just the next few months—the current benefit structure may have to again be pared back. Many policymakers are raising the likelihood of having to increase beneficiary cost sharing further to meet the budget target. Although you may not want to reduce Medicare benefits or payments to providers, we also recognize that your Committee must choose between some cuts in Medicare and relatively more major cuts in programs under your jurisdiction which are specifically designed for the low income—such as SSI, AFDC, and heating assistance.

Both of the bills before the Subcommittee propose to cover a very broad scope of services. It has been our observation that sometimes when the Medicare program covers a new benefit, the total supply of and the demand for those new benefits grows rapidly, and their costs often outstrip any potential savings for specific, selected cases or patients. We believe that could happen in this case.

Given these new costs of the benefits under consideration and the likelihood that the Congress will once again make at least some cuts in the existing Medicare program, we urge you to postpone covering any new benefits until the point in the budget process where you can weigh the value of proposed benefits against the value of existing coverages threatened by such cuts.

Sincerely,

**James D. Isbister,**
*Senior Vice President for Federal Programs.*

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## Statement of Cancer Care, Inc.,

Cancer Care, Inc., and The National Cancer Foundation has for over 38 years, provided professional social work counseling to cancer patients and their families. Each year nearly half of the patients and their families. Each year nearly half of the patients we serve are over 65 and Medicare eligible. We are, therefore, very experienced in counseling the elderly.

We are very appreciative of the acknowledgement given to H.R. 6092 by conducting a hearing on the proposal last month. We trust that this communication from us will be included in the report on the hearing.

We are heartened by the fact that this proposal gives recognition to the education, skills and experience of qualified social workers and places them on a par with other mental health professionals. Indeed, the social work profession has traditionally been very involved in providing concrete services as well as counseling to the elderly. The new law offering Medicare coverage for hospice care acknowledges this by including social work as one of the core services to be offered by hospices.

H.R. 6092 endorses the concepts that mental health services to the elderly can be effectively offered by qualified social workers, and that elderly persons and their families should have the opportunity to choose the mental health discipline which is most appropriate to their particular emotional and adjustment problems.

Social work fees for counseling are usually considerably less than those of psychiatrists or psychologists. Social workers, by training and philosophy, are more tuned in to the environmental factors which may impinge upon the very fabric of the elderly person's life. Further, the education and training of qualified clinical social workers equips them to evaluate the patient's emotional condition, and know when psychiatric and/or medical care is needed.

We are pleased that former Congressman Fithian and other legislators acted upon the President's Commission on Mental Health's recommendation that psychiatric nursing, psychiatry, clinical psychology and clinical social work be reimbursable mental health treatment providers.

We hope that a proposal modeled upon H.R. 6092 will be introduced and acted upon favorably in the 98th Congress.

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**Cheshire Hospital,**
*Keene, N.H., January 18, 1983.*

Hon. **Andrew Jacobs,**
*Chairman, Health Subcommittee House Ways and Means,*
*U.S. House of Representatives, Washington, D.C.*

**Dear Mr. Jacobs:** On behalf of the residents of Keene and Cheshire County New Hampshire, we submit this plea for favorable action on H.R. 3921 for which hearphychiatric nurse specialists most commonly charge fees notably less than physicians.

In sum, I urge support for this bill and its expansion of Medicare and Medicaid coverage to include reimbursement of non-physician mental health providers because the elderly and poor will be better served, skilled mental health professionals with varied expertise will be more fully utilized, and that H.R. 6092 will prove to be a cost effective use of national health resources.

Sincerely,

GEORGE BRAGER, *Dean.*

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COMMUNITY HOSPITAL OF OTTAWA,
*Ottawa, Ill., January 13, 1983.*

Hon. ANDY JACOBS, Jr.,
*Chairman Subcommittee on Health, Committee on Ways and Means,*
*U.S. House of Representatives, Longworth House Office, Washington, D.C.*

DEAR HON. JACOBS: I would like to take this opportunity to express my appreciation for giving the opportunity of writing my impression of H.R. 3921 providing reimbursement for personal emergency response systems. I would like to express my opinion as a health professional and also the feeling of the Community Hospital of Ottawa in support of H.R. 3921.

In today's society with high mobility, we find many senior citizens being quite frail or being just quite concerned about living alone. Consequently, there seems to be a great tendency to move into sheltered care or nursing home environments to alleviate these concerns of living by themselves. As an individual ages, the concerns in being by themselves and possibly injuring themselves or having a major medical emergency at times when assistance would be somewhat questionable, has in my opinion, caused this particular movement toward more costly sheltered care or nursing home environments.

Medicare, as is well publicized, is presently under great financial pressures in caring for the aged; consequently, it would only seem natural to me that individuals administering the Medicare program would be looking at less costly ways of providing care. If a senior citizen is able to live by himself and take care of himself, knowing that emergency help is only a response away, this might subdue a move toward a more structured setting and allow our senior citizens not only the freedom and independence of living along but also security that care can be derived as appropriately necessary.

I would highly recommend that the Committee consider the minimal expenses this would involve as compared to what the cost nursing home facilities cost today and that possible spending minimal dollars in reimbursement in this area might well save the big dollars necessary for nursing homes or, if medical conditions go unnoticed for some time, the much more major expense of hospitalization that would incur.

It is my impression in the past many government programs try to save a few dollars now and end up spending big dollars as a result. This is an opportunity to forestall that and possibly spend a few dollars now and save the big dollars that might have been spent in the future. This could be a very vital step in putting Medicare back on a financially viable course.

Again, I would like to express my appreciation to the Committee for providing me an opportunity to express my views and I am looking forward to the deliberations and recommendations of this Subcommittee.

Respectfully,

YALE M. WOLK, *President and Chief Executive Officer.*

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COUNSELING ASSOCIATES, INC.
*Southfield, Mich., December 7, 1982.*

JOHN J. SALMON,
*Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Longworth House Office Building Washington, D.C.*

DEAR MR. SALMON: As the Executive Director of a multi-disciplinary clinic, I am writing you with regard to Congressman Fithian's Bill H.R. 6092. I have long been amazed that Medicare and Medicaid only reimburse psychiatrists. Delivery of mental health services should be multi-disciplinary to include clinical social workers, psychologists and psychiatric nurses. It would be in the best interests of patients to be diagnosed and served by a multi-disciplinary team that can take into account the total mental health picture of each patient. That is how services are delivered at our Clinic where we do not just use the psychiatrist to provide mental health service for patients. It seems that the current provision of services to Medicare and Medicaid patients is way behind the times. Psychiatrists are the most expensive providers of these services yet can only serve a limited number of people. There are so few psychiatrists available as compared with the other three abovementioned professions. In fact, it should be noted that clinical social workers provide the majority of mental health services in this country as was stated in Rosalind Carter's report on the status of mental health in the United States.

Since many insurance companies do reimburse for clinical social work and psychological services to patients, it is quite discriminatory against Medicare and Medicaid recipients to only be able to go to psychiatrists. Many states indeed have "freedom of choice" legislation that decrees that where mental health services are provided by an insurance company, the patient be given the freedom of choice as to whether to use a psychiatrist, clinical social worker or psychologist. It should be noted that many studies have shown that use of mental health services cuts down on medical care usage. Therefore, the provision of mental health services to more than just the limited number of patients that psychiatrists can see, should indeed cut down on the far more expensive medical care usage by Medicare and Medicaid recipients. (Note the Kaiser-Permanente study amongst others.)

I support Congressman Fithian's H.R. 6092 as cost effective. It would not increase the dollar amount of benefits reimbursed by Medicare and Medicaid but would only give the "freedom of choice" to Medicare and Medicaid recipients that most other people in this country share.

Please do not hesitate to call me if I can be of any further help in testifying about this matter.

Sincerely,

**Sidney H. Grossberg**, Ph. D., *Executive Director.*

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Fort Washington, Md., *December 31, 1982.*

Hon. Andy Jacobs, Jr.,
*Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Longworth House Office, Washington, D.C.*

Dear Mr. Jacobs: I am writing in regard to H.R. 6092 and wish my letter to be submitted as part of the hearing record. I am enclosing five (5) copies of my testimony as required.

It is my opinion that H.R. 6092 is in the best interests of the public; specifically, freedom of choice in regard to mental health services is a right of the consumer and secondly, mental health specialists other than psychiatrists can and do deliver comparable services at significantly lower costs.

In regard to my first point, that the public has a right to freedom of choice among competent mental health specialists, it seems self evident that fair competition allows the consumer the opportunity to "shop" and determine for himself which practitioner and which profession can best serve him. The present system of allowing only psychiatrists to render mental health treatment and receive direct reimbursement under Medicare and Medicaid seems to me to be monopolistic and in the service of restraint of trade.

In regard to allied mental health specialists offering competent and broad ranges of services at significantly lower costs this has been documented by CHAMPUS in a recent study of reimbursement of clinical social workers during a period from October 1, 1981 through March 31, 1982 during which period CHAMPUS realized a cost avoidance of $253,000.

H.R. 6092 does not seek to increase Medicaid and Medicare costs, nor require changes in reimbursement procedures. It is my judgment that this bill is properly in keeping with current government policy to reduce Federal spending.

I very much appreciate your help in moving this bill forward.

Sincerely,

**Jean Driggers**, MSW, LCSW.

FLAGLER HOSPITAL, INC.,
*St. Augustine, Fla., January 18, 1983.*

Hon. ANDREW JACOBS,
*Chairman, Health Subcommittee, House Ways and Means Committee, U.S. House of Representatives, Longworth House Office Building, Washington, D.C.*

DEAR REPRESENTATIVE JACOBS: This letter is in support of HR 2931, to provide coverage by Medicare for reimbursement for personal emergency response systems for qualified Medicare recipients.

Flagler Hospital, in cooperation with the Pilot Club of St. Augustine, has been a participant in the Lifeline personal emergency response services program for the past fifteen months. Our program now has 27 units in use in our county, and has responded to a sufficient number of medical emergencies to convince us that the system does in fact work, and that it has the capacity for saving lives and greatly reducing institutionalization of the elderly handicapped who have a strong will to remain in their own homes.

Due to the high initial cost of the program, it has been necessary for us to progress at a slow pace. Although we feel that it is definitely meeting a clearly demonstrated need in the community, many of the people who would benefit most from the program are unable to afford it because they are living on limited, fixed incomes.

I firmly believe that if HR 2931 is passed by the 97th Congress, it will make it possible for many more needy and deserving persons to be served by this highly effective means of permitting them to avoid institutionalization, yet remain safe in their homes with the assurance that they can summon emergency assistance if needed.

A brochure describing the Lifeline program is enclosed for your information. The system works. Now we just need a better way of making it available to all who need it. Your support is earnestly solicited.

Sincerely,

CLAUDE L. WEEKS, *Executive Director.*

**LIFELINE®**
**PERSONAL EMERGENCY RESPONSE SYSTEM**

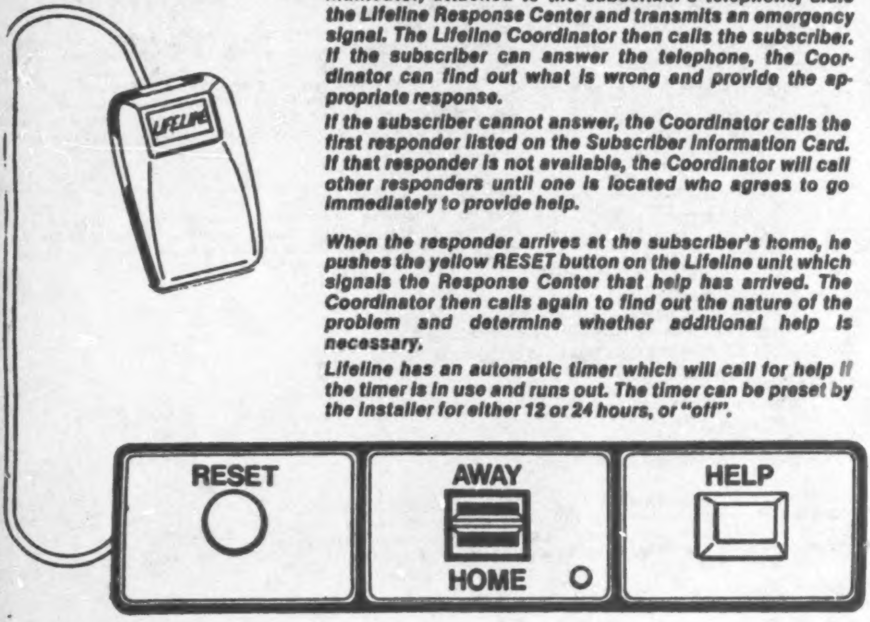
*Lifeline is a personal emergency response system designed to help people live independently, confident that they will be helped if an emergency occurs.*

*The Lifeline system provides for 24-hour/day monitoring by trained personnel. At the first indication of trouble, the subscriber pushes a button and the Lifeline Communicator, attached to the subscriber's telephone, dials the Lifeline Response Center and transmits an emergency signal. The Lifeline Coordinator then calls the subscriber. If the subscriber can answer the telephone, the Coordinator can find out what is wrong and provide the appropriate response.*

*If the subscriber cannot answer, the Coordinator calls the first responder listed on the Subscriber Information Card. If that responder is not available, the Coordinator will call other responders until one is located who agrees to go immediately to provide help.*

*When the responder arrives at the subscriber's home, he pushes the yellow RESET button on the Lifeline unit which signals the Response Center that help has arrived. The Coordinator then calls again to find out the nature of the problem and determine whether additional help is necessary.*

*Lifeline has an automatic timer which will call for help if the timer is in use and runs out. The timer can be preset by the installer for either 12 or 24 hours, or "off".*



**LIFELINE**
IS OPERATED BY
**FLAGLER HOSPITAL**
IN COOPERATION WITH
**THE PILOT CLUB**
OF ST. AUGUSTINE

POSTAGE
STAMP
HERE

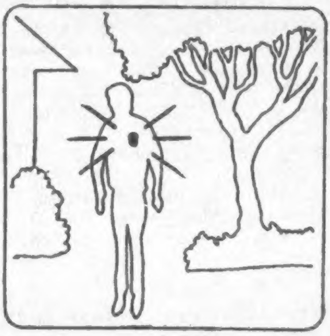
# FLAGLER HOSPITAL

P.O. Box 100
St. Augustine, Fla. 32084

Executive Director
ATTN.: ~~Hospital & Community Relations Dept.~~

# LIFELINE®

## The personal emergency response system



**HOW DOES IT WORK?** Your Lifeline unit consists of two parts, a small "call box" which you carry around on your belt and a "telephone sender unit" which attaches to your home telephone. In the event of an emergency, simply press a button on your "call box" and it automatically triggers the "telephone sender unit." The sender unit immediately sends a message to our 24-hour response center that you need help.

**WHAT DOES THE RESPONSE CENTER DO THEN?** As soon as we receive your distress signal, our response center operator calls you back. If you answer, we determine the nature of your problem and help you out accordingly. If you don't answer, we assume you need help quickly. We then call whoever you have listed as your "primary responder" in our files. This could be a neighbor, relative, or whomever you designate. If none of the primary responders are home, we then call the police. In any case, you are assured that help WILL come and that you will not lie unassisted.

**WHEN DO I USE IT?** The Lifeline program is designed to provide you with immediate help in the event of an emergency. Although only you can decide what a true emergency is as far as you are concerned, we can offer you some examples: a disabling fall; unexpected dizzyness or nausea which could indicate heart or respiratory trouble or a blackout; unexpected breathing difficulty; or even if you hear a prowler trying to break into your house. The best way for you to decide about medical reasons would be to talk to your doctor.

**HOW FAR AWAY WILL THE "CALL BOX" WORK?** Its range is about 210 feet (70 yards) from your telephone set. This gives you great mobility around the house and yard, and allows your responder to locate you quickly in the event of problems.

**CAN WE HAVE MORE THAN ONE CALL BOX PER HOUSEHOLD?** Yes, for a small additional fee, we will provide you with extra call boxes which will work with your home telephone sender unit.

**HOW DO I KNOW THE EQUIPMENT IS WORKING?** We will make a monthly call to you to test the equipment.

**WHAT IF I ACCIDENTLY PUSH THE EMERGENCY BUTTON?** No problem. When the Lifeline operator calls to confirm the emergency, simply tell her the call was an accident.

**IS LIFELINE ONLY FOR THE ELDERLY?** The Lifeline program is for anyone. It is available on a permanent or temporary basis depending on the individual's needs. An elderly couple with no history of health difficulty may participate simply as a precautionary measure. Even a young expectant mother may utilize Lifeline while her husband is away for extended periods.

**WHAT ARE MY OBLIGATIONS?** The only charges for Lifeline are an installation fee and the monthly rental. After signing the basic rental agreement, you may drop out of the Lifeline program anytime you wish, just give us three days written notice.

[Clip along this line]

### SUBSCRIBER APPLICATION FORM

Name____________________ Age______ Telephone __________

Address____________________ Zip__________

Physician ____________________

List your health difficulties: ____________________

What is the general nature of your health care difficulty?

Mobility_____ Cardiac_____ Respiratory_____ Precautionary_____

TOTAL CHARGES FOR THE LIFELINE PROGRAM: ONE TIME INSTALLATION FEE OF $10, PLUS $15 PER MONTH. CALL US FOR FURTHER DETAILS 824-8411 EXT. [redacted]R 364.

FLAGLER HOSPITAL
159 MARINE STREET
ST. AUGUSTINE, FL
32084

GEORGETOWN UNIVERSITY HOSPITAL,
*Washington, D.C., January 5, 1983.*

Re: H.R. 6092.

Hon. ANDY JACOBS, Jr.,
*Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Longworth House Office, Washington, D.C.*

DEAR HONORABLE JACOBS: I am writing in support of H.R. 6092. Patients request and obtain mental health services by non-physician providers. I see patients both in my private practice in Rockville, Maryland and at Georgetown, as Director of the Biofeedback Programs. At Georgetown alone I have seen or supervised over 1,200 patients since 1976. Patients seek my services both as a family therapist and for the treatment of psychophysiological disorders and stress management with biofeedback. The referrals come from a variety of professionals including physicians. In fact, for the treatment of psychophysiological disorders I require that patients see a physician first. But after that, the service is directly betweeen the patient and myself. This is extremely cost-effective: I charge $50 per 50 minute session and frequently less than 10 sessions are necessary. When patients are not covered by insurance for my services as a clinical social worker, in fact they are denied freedom of choice. This is ironic considering that I receive referrals not only from professionals in the metropolitan area but also nationally from as far as California and Denver about patients who reside or move to this area.

Again, please support H.R. 6092 for the benefit of a very large segment of the population.

Respectfully yours,

LILLIAN ROSENBAUM, LCSW, Ph. D.,
*Clinical Associate Professor,*
*Director, Biofeedback Programs.*

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SILVER SPRING, MD., *January 10, 1983.*

Hon. ANDY JACOBS, Jr.,
*Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Longworth House Office, Washington D.C.*

DEAR CONGRESSMAN JACOBS: This letter is to request that you support H.R. 6092 which amends the supplementary medical insurance part of the Medicare and Medicaid to provide direct reimbursement for covered mental health services provided by psychiatric social workers.

As you may be aware, currently only physicians can be reimbursed. Adding psychiatric social workers has the advantage of making skills available to people from practitioners who have been providing psychotherapeutic services since the inception of mental health. Their expertise in helping to resolve disturbed parent-child relationships, marital conflicts and personal problems of all kinds are well established. Services to the poor and the aged are often considered to be the specialties of the social work profession.

As a board member of the Greater Washington Society for Clinical Social Work, I urge you, for the reasons given above, to support this bill.

Sincerely,

HERMAN A. GEWISGOLD, MSW, LCSW,
*Psychiatric Social Worker.*

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SANTA ANA, CALIF.

Re: Adding a further amendment to H.R. 3921, Heckler, Pepper, H R. 6092 Fithian or a new bill proposal that would provide direct reimbursement for mental health orientated services provided by an Adult Day Health Care and Treatment Center as an alternative to institutionalization for adults covered by SMI insurance.

Hon. ANDY JACOBS, Jr.,
*Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Longworth House Office, Washington, D.C.*
(Attention of John L. Salmon)

HONORABLE SIR: This suggested proposals is for an incorporated non-profit center which would be:

1. Medical model with the private or clinical physican referring his or her qualified patients to this center, prescribing physical, psychological and social rehabilitation activities, advanced and new medications and treatments, evaluate progress and continued follow up of those patients that are in danger of institutionalization, but could remain in home setting. Cost to taxpayer and to the patient would be about half.

2. Cost effective with a daily average census of 200 patients. Reimbursement to the center would be subject to the usual deductible and co-insurance requirements of the medicare program. Patient financial arrangements are as follows: (a) 80 percent of the patients will be on medicare, (b) 10 percent will be private, including insurance cases. The highly trained staff would get patient back to work before an illness attitude became permanent, resulting in an early retirement, (c) 10 percent of those in need but do not qualify for medicare will get free service. Existing federal, state, and local, as well as private funds will be sought.

3. Objectives—

(a) To create a program of hope for those adults needing this service, and a pride of community in a program that is creative, functional, cost effective, and one that gets results in helping the patient in returning to wellness within his physical and mental capacity. This program will not be a "dead end" or a "Gestapo" like prison. Depending upon the condition and progress, the patient will be transferred by his private physician to a less costly Adult Day Care, or to a Skilled Nursing facility.

(b) To help adults, especially frail elderly, with temporary or with permanent disability to recondition life style for living with limitations in home and participation in community activities.

(c) To provide a modern scientific well balanced learning and work experience for all persons preparing for disciplines as they relate to gerontology.

4. Staffing by well qualified mental health oriented professionals.

(a) A well qualified gerontological nurse administrator with assistants responsible for in-service and for educational programs, a psychiatric public health nurse practitioner to coordinate mental health, health education, and gerontologic education and practice for patients and for staff.

(b) Geriatric Clinical Nurse Practitioner (One assistant will be added for every 25 patients) Qualifications: education and experience in psychiatric (Mental Health) and gerontological nursing with a clinical specialty. Clinical areas to be provided: (1) Post Cardiac Nursing, (2) Medical, Obesity, diabetics, nephritis, etc., (3) Neurological nursing-medical and surgical, (4) Alzheimer's Disease and related disorders. It is reported that some 10 diseases resemble this condition. All of which need careful observation and treatment. (5) Orthopedic Nursing, (6) A drug and treatment practitioner.

(c) The rehab. Staff: Physical, occupational, recreational therapist, the psyc. social worker, dietitian, and others will work with the nursing staff as a team stressing wellness for each patient. Mental Health preparation will be required for these workers.

(d) Business, stenographic and grounds personnel as needed.

(e) Qualified professional retirees will be hired as part time workers in areas of proficiency or unemployed can be retrained for new professions.

5. The need for the Adult Day Health Care and Treatment Center.

"Older adults use health care services more extensively than any other segment of the population. They are hospitalized more frequently. One in six is hospitalized yearly as compared to one in ten for the remainder of the population, and once in the hospital they stay longer. Health care costs them more. They spend yearly three times that spent by younger adults. Personal health care for older adults accounts for 30 percent of the money spent for health care in this country. Older adults are at greater risk for alterations in their status because of the changing physiological, psychological and socioeconomic conditions affecting them. They experience more life crises, chronic disease, sensory loss and deterioration mobility and daily functioning as a result of the aging process. Despite changes in their health status, only five percent of older adults are institutionalized. Most frail elderly are living in the community, alone, with family or in board and care facilities." [1]

In Orange County there are 3000 adults in 61 rest homes (skilled Nursing Facilities) filled to 98 percent capacity. It is estimated by the administrators of these agencies that 5-10 percent of their patients do not need to be hospitalized if an alternate program were available. The cost for these patients not needing institutionalized care, is about double for that of the Adult Day Health Care And Treatment Center. This would be quite a saving to the tax-payer.

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[1] HEW (acts about Older Americans 1976, DHEW Pub. No. (OHD) 77-20006) Washington, DC Printing Office 1976.

With the rapidly increasing number of older adults, this population can be expected to number 3 to every 20 years old by the turn of the century. By then, many seniors will celebrate their 100 birthday. Will they be living vegetables needing total care or will many of them remain community active? The decision is the responsibility of the government. This decision is currently being made. You are in the drivers seat? The private-public partnership needs to be effected with public policy squarely on the side of financial assistance for alternatives to institutional care in order to assure the survivability of the family. Today most people are either grandchildren or grandparents—sometimes both—for a good part of their lives.

With the increasing numbers of frail elderly, Alzheimer's disease is becoming one of Americas growing problems. It is estimated that there are 1½ million victims and millions of family members involved. It is not "just senility", it is a disease that involves degeneration of the neurons with cause as yet unknown. The symptoms include gradual, progressive decline in memory, learning, attention and judgement, disorientation in time and space, difficulties in word finding and communication, and personality changes. It usually strikes the 40' and 50' year old and thereafter. It is the fourth leading cause of death. It strikes persons of all socioeconomic circumstances and ethnicities. 60 percent of all patients in nursing homes carry some diagnosis of this illness. The cost is around $20,000.00 each, yearly. Depression often coexists and this is treatable. Excerpts from Generations, The Journal of Western Gerontological Society.

6. Recommendations.

(a) To establish direct reimbursement by medicare for mental health orientated services to be provided by the adult day health and treatment center, perhaps as a pilot project, as an alternative to institutionalization for adults covered by this insurance (SMI). That the physical, psychological and social rehabilitation programs be incorportated in non-profit medical model, administrated by a qualified mental health orientated staff working as a team for effective return of adults to community living and activity. Religious practice is to be the responsibility of the church.

(b) That these centers be used as educational and work experience for those in the field and for newcomers, currently unemployed.

AILEEN JEISY JOHNSON,
*Chairman Pro Tem, Adult Day Health Care and Treatment Center of Orange County, and an elected Assemblyperson to the California Senior Legislature.*

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LAKEWOOD HOSPITAL,
*Lakewood, Ohio, January 11, 1983.*

Hon. ANDREW JACOBS,
*Chairman, Health Subcommittee, House Ways and Means, U.S. House of Representatives, Longworth House Office Building, Washington, D.C.*

DEAR CHAIRMAN JACOBS: As Coordinator of Lakewood Hospital's Lifeline Program, I am very much in favor of Medicare, Part B, being amended to include reimbursement for personal emergency response services (H.R. 3921).

As one of the largest programs in the area, Lakewood Hospital's Lifeline program has received tremendous support from the medical and nursing staff, outside nursing agencies. Office on aging, local government, and the general public. I am quite often a guest speaker at church groups, Kiwanis Club, and womens' group meetings. We have also received large donations from some of these groups. It appears obvious that the public has not only accepted the introduction of personal emergency response systems, but that they will do what they can to increase the use of these devices.

Since the inception of our program in September, 1981, our Emergency Response Center has responded to 27 calls for help. The majority of these calls were due to falls when the subscriber could not possibly have gotten to a telephone. Most of these individuals would have been laying on their floors in pain for several hours would they not have had Lifeline.

In August, 1982, I conducted a survey of our Lifeline subscribers to assess their feelings about Lifeline. I have enclosed a summary of some of their remarks.

I feel strongly that with the passage of H.R. 3921, we will begin to see a reduction in length-of-stay in hospitals as well as a reduction in nursing home admissions. Research has shown that people want to stay in their own homes. With the availability of Lifeline, those unable to before, are now able to live independently in their own homes.

Sincerely,

**Marla R. Daugherty,**
*Lifeline Coordinator.*

Enclosure.

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## LIFELINE USER'S SURVEY "QUOTABLE QUOTES"

After the recent survey sent out to all of Lakewood Hospital's Lifeline Subscribers we thought you may enjoy reading some of the comments to the last question on the survey which was as follows: Do you have any comments or suggestions concerning lifeline?

"Feel very safe with it in the house."

"I am very satisfied with it."

"Good to have."

"All I can say, it could be a life saver."

"Just wish more hospitals had the Lifeline Program throughout the U.S.A. A program worth the money and very rewarding."

"Since I have Lifeline, I feel more secure and more relaxed. Being a heart patient I have the feeling I have a life guard."

"I feel I have help, if needed, at my fingertips."

"I'm very satisfied and safe having the Lifeline."

"I think it is a splendid plan for anyone who lives alone."

"It's a fine, helpful unit."

"I think it's a fine thing and should make disabled persons much relieved in knowing they can reach help in this manner."

"I think it's great!"

"This lifeline gives me a feeling of great security with the idea of getting help in any emergency for I have it on my person at all times, day and night, and it also gives my family peace of mind that I have help—if needed—immediately!"

"A comment, yes, the people responsible for the function of this wonderful service are to be complimented. My thanks to them!"

"It is a wonderful thing. Many more individuals should have it."

"Good for any person with a bad heart."

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**Lee Hospital Lifeline,**
*Johnstown, Pa., January 21, 1983.*

Hon. **Andrew Jacobs,**
*Chairman, Health Subcommittee, House Ways and Means, U.S. House of Representatives, Longworth House Office Building, Washington, D.C.*

**Dear Sir:** This letter is to express my support of H.R. 3921 amending Medicare Part B to include reimbursement for personal emergency services.

Specificially, I would like to write on behalf of Lifeline. Lee Hospital was the first hospital in Pennsylvania to have a functioning Lifeline service and as the Medical Director of such emergency services, I am convinced of the usefulness of this device for people who are socially isolated or who have chronic and debilitating diseases.

Although the majority of the subscribers are senior citizens, this program also includes young people with multiple chronic diseases who live alone. The health care cost saving is obvious as internment of disabled or socially isolated senior citizens into expensive nursing homes can be delayed or prevented. There are also many psychological benefits including the sense of self-esteem that these people experience by being able to remain independent and self-sufficient.

It is very clear that Federal reimbursement will enable additional hospitals to administer Lifeline Programs more effectively and it could be offered to people who could not afford even the nominal charge. Because of age or disability, many Lifeline subscribers are already on Medicare/Medicaid and if this program could be expanded, more people could be served by the Lifeline emergency program.

The Lifeline network of first responders does not displace the support of family and friends of the elderly and disabled, but makes it more effective and reinforces the family connections.

In closing I would like to say that I regard Lifeline as an essential long-term care service and, therefore, an integral part of the long-term care delivery system for the elderly and disabled.

Sincerely,

CARLOS H. CASTELLON, M.D.,
*Director, Department of Emergency Medicine,*
*Medical Director, Lee Hospital Lifeline.*

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LEE HOSPITAL LIFELINE,
*Johnstown, Pa., January 17, 1983.*

Hon. ANDREW JACOBS,
*Chairman, Health Subcommittee, House Ways and Means, U.S. House of Representatives, Longworth House Office Building, Washington, D.C.*

DEAR SIR: I am writing this letter to support federal legislation to amend Medicare, Part B, to include reimbursement for personal emergency response services; specifically H.R. 3921.

Being the Lifeline Coordinator of the first Lifeline system to be installed in the Commonwealth of Pennsylvania (Lee Hospital Lifeline, Johnstown, Pennsylvania), I feel I am experienced and knowledgeable to voice my support for such a bill. Lee Hospital has long been an institution concerned with long-term care services and costs, and we now consider our Lifeline Program an essential and integral part of this delivery system in our community. Working closely with neighboring hospital Social Service Departments, we feel we are definitely reducing long-term care costs. Many of our subscribers have been able to stay at home, live independently, and maintain a feeling of security only with the installation of a Lifeline home unit. Many families have opted to install a Lifeline unit instead of placing a loved one in a long-term care facility. I believe this to be our program's major cost saving feature.

All but one of our subscribers is a senior citizen. They have had Lifeline installed so they will have immediate contact with someone who cares and can help them in any emergency situation (medical or environmental). It relieves their anxiety and the anxiety of their families and/or friends.

Our area has a large populace of senior citizens who live alone. I feel federal reimbursement would enable our hospital to better administer the Lee Lifeline Program, mainly because I believe it would bring us in contact with people who cannot afford the even nominal monthly rental fee we require. Johnstown and the surrounding area senior citizens like all the elderly in our great country are very proud citizens and I feel this reimbursement would bring many to our attention that would otherwise be unknown.

Personal experiences with our Lifeline Program have given me a very rewarding feeling helping our elderly and their families, friends, and neighbors. The emergencies our system has handled have not only saved lives, but has reduced hospital stays and many times has eliminated them, but getting to the subscriber immediately after serious falls, diabetic attacks, heart attacks, etc.

I personally hope you will find my letter in some small way a plus for securing the approval of H.R. 3921. It would make me very proud for Lee Hospital Lifeline and myself.

Sincerely,

LANNY R. STINSON,
*Paramedic II,*
*Lee Hospital Lifeline Coordinator.*

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MERCY HOSPITAL,
*Springfield, Mass., January 10, 1983.*

Hon. ANDREW JACOBS,
*Chairman, Health Subcommittee, House Ways and Means, U.S. House of Representatives, Longworth House Office Building, Washington, D.C.*

DEAR REPRESENTATIVE JACOBS: I am writing in support of H.R. 3921—a bill which would provide Medicare coverage for personal emergency response services.

Mercy Hospital has been a participant in the Lifeline system for the past three years. We presently have over seventy units in service. It is our experience that the frail elderly who have Lifeline units are able to remain independent. This is a cost savings to the Medicare program, because they are able to remain in their own homes and not confined to nursing homes. Although our charge is very modest

($12.00 a month), many of our clients are unable to afford the units. We have an arrangement with our hospital auxiliary for "tuition" to cover some of our indigent clients.

I strongly support H.R. 3921 as a cost saving measure as well as a very humane and socially necessary program. I would be happy to speak with anyone on your staff if you have any questions.

Sincerely,

Sr. MARY CARITAS, S.P.,
*President.*

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MERCY HOSPITAL,
*Springfield, Mass., January 11, 1983.*

Hon. ANDREW JACOBS,
*Chairman, Health Subcommittee, House Ways and Means, U.S. House of Representatives, Longworth House Office Building, Washington, D.C.*

DEAR REPRESENTATIVE JACOBS: I am writing to request your support of H.R. 3921. This bill will amend Title XVIII of the Social Security Act to provide medicare coverage for Lifeline services.

As you probably know, Lifeline is an inexpensive personal emergency response system which may allow frail or disabled persons to live with independence and security in their own homes. In some cases, the Lifeline may provide the difference between institutional placement versus independent living. At a cost of 12 to 20 dollars per month, this seems to be an effective and reasonable solution for a number of our infirm elderly and/or disabled citizens in the community.

At the present time, Mercy Hospital has 62 Lifeline subscribers. There are many more people on a waiting list, as our ability to fund the growth of this system is outstripped by the demand for it. There are also those in the community who have chosen to do without the Lifeline because they do not wish to pay the $12.00 per month user fee. For these people, there is simply too much competition for the scarce financial resources at their disposal.

Mercy Hospital considers the Lifeline System an important breakthrough in enabling our elderly and disabled patients a degree of independence that they would otherwise not enjoy. It not only prevents unnecessary long term institutionalization, but contributes to a shorter length of stay for those patients who are in acute care institutions and who can be discharged earlier because of the availability of the Lifeline support system.

We at Mercy Hospital would be happy to provide you or any members of your subcommittee any additional first hand information which we can provide. Please feel free to contact us, either by mail or by telephone at (413) 781-9100 ext. 2321.

I appreciate your consideration in this matter and am hopeful that you will find this program worthy of legislative support.

Sincerely,

EUGENE J. MCCUE,
*Vice President/General Services.*

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MERCY HOSPITAL AND MEDICAL CENTER,
*San Diego, January 31, 1983.*

Hon. ANDREW JACOBS,
*Chairman, Health Subcommittee, House Ways and Means,*
*U.S. House of Representatives, Washington, D.C.*

DEAR MR. JACOBS: This letter is in support of current Legislation H.R. 3921 which was introduced by Mrs. Heckler and Mr. Pepper to provide Medicare coverage of personal emergency response services.

Mercy Hospital and Medical Center introduced the services to the San Diego community in April of 1981. The services have been enthusiastically received by the community. However, there still remains those individuals living alone that do not have the resources to cover the cost of providing the services. The emergency response system allows the elderly and disabled person to live independent lives with the assurance that emergency support is available and nearby. We feel this emergency response system is cost effective in that people do not require skilled environments such as you would find in skilled nursing facilities or other long term facilities.

Once again, I would like to encourage your support of the current Legislation as a means of enhancing the quality of life for the aged and disabled person who would be utilizing such services.

Thank you very much for your attention.

Sincerely,

ROBERT W. BROWN, *Associate Administrator.*

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## STATEMENT OF ALVIN GOLDBERG, MOUNT SINAI MEDICAL CENTER OF GREATER MIAMI

My name is Alvin Goldberg, Executive Vice President of Mount Sinai Medical Center of Greater Miami. I am very pleased to submit this statement for the record of the hearing to examine proposals to provide Medicare Coverage of personal emergency response systems on December 14, 1982. I am writing to the Subcommittee on Health of the Committee on Ways and Means in support of Medicare coverage of personal emergency response systems.

Mount Sinai Medical Center is acutely aware of the needs of the elderly within our community and the costs associated with acute inpatient care and skilled nursing care. Mount Sinai Medical Center serves an area where the population is especially skewed in the direction of the upper age groups, Miami Beach, where 52 percent of the population is over the age of 65. This figure is especially significant when juxtaposed with the lessor Dade County total of 16 percent and the State of Florida estimates of 17 percent of the population 65 years and older. This is clearly the highest concentration of elderly in the nation. South Miami Beach in particular has a disproportionately large number of elderly reporting 59 percent of the population over the age of 65.

Mount Sinai Medical Center has, because of its location on Miami Beach, been particularly cognizant of the problems of the aged. Over 75 percent of the patient days of the hospital are for those 65 and older. In addition, 46 percent of our patient days are for those 75 and older, what we call the old-old population. This high prevalence of geriatric patients is hardly approached by any other general medical institution in the nation.

Since Mount Sinai Medical Center is intimately involved with the 65 and older population, we are acutely aware of the special problems of the elderly. Mount Sinai operates our own emergency response system, ARMS (Automatic Response Monitoring System), in operation since January 1981 providing over 220 frail, indigent elderly people throughout the community with immediate access to health care during a medical emergency. Our program, which is one of the largest in the country, was offered through a state sponsored grant to elderly people participating in Florida's Community Care for the Elderly Program. However, this funding covered only the cost of the equipment and does not cover the cost of maintaining and monitoring the equipment and calls for assistance which, in and of itself, creates the quality of the ARMS program. If reimbursement were possible under the Medicare laws, we could continue and possibly expand ARMS to a population much in need of such services.

Evaluation of the personal emergency response systems have shown extremely beneficial results to the elderly and society as a whole. First, a study for the Department of Health and Human Services demonstrated the effectiveness of personal emergency response systems to the frail, isolated or functionally impaired elderly in preventing premature or inappropriate institutionalization.

This study, conducted by researchers at the Hebrew Rehabilitative Center for the Aged and Boston University's Gerontology Center concluded that the elderly person living alone functioned more comfortable and independently, reduced the need for nursing home care (one day in a nursing home compared to an average of ten nursing home days for a control group during the 14 month study), and reduced long term care cost due to a reduced use of both institutional and community services (each dollar spent for the emergency response system produced a net savings of $7.19 in total long term care cost).

Second, the ARMS program has recently been evaluated by Mount Sinai Medical Center with the findings presented to the American Public Health Association's 110th Annual meeting in Montreal, Canada in November 1982. The conclusion of this study was that the ARMS program reduced the need for institutionalization, permitted the elderly to live with greater independence in their homes, and as recipients of Community Care for the Elderly funds, case management could be coordinated to receive a full spectrum of social support services. This tie in is very important as few of the ARMS clients have a formal support system upon which they can help. Mount Sinai's study, ARMS, an evaluation of emergency response services for the elderly is Appendix 1 of this testimony.

Mount Sinai Medical Center firmly believes that these personal emergency response systems merit coverage under Medicare law. We want to continue to service the indigent elderly in our community with ARMS. Medicare reimbursement for personal emergency response systems such as ARMS would save the government costly Medicare expenditures and expensive acute or long term health care services.

In conclusion, Mount Sinai Medical Center strongly supports legislation providing the Medicare reimbursement of personal emergency response services to the elderly. I hope this committee undertakes serious consideration of the benefits to the elderly at large as well as the reduced government costs associated with those services. Your support for such legislation will be extremely important. Once again, I thank you for the ability to submit this testimony. If you require any further assistance or information, please feel free to call upon me.

## APPENDIX 1

## ARMS: AN EVALUATION OF EMERGENCY RESPONSE SERVICES FOR THE ELDERLY

(Presented at American Public Health Association's 110th Annual Meeting in
Montreal, Canada, November 17, 1982)

### INTRODUCTION

With predictions of a rapid growth of the older population (by the year 2000, persons 65 and older will comprise 12.1 percent of the nation's population), we are faced with a number of new issues. As a group, the elderly are more likely than younger people to suffer from chronic, often permanent conditions that may be disabling. Independence is a major factor in maintaining a satisfying quality of life among the elderly who are alone, physically impaired, or handicapped. Now emergency alarm systems have been developed to provide the needed emotional security and physical help for medical emergencies to this vulnerable population group.

A study for the Department of Health and Human Services, conducted by the Hebrew Rehabilitation Center for the Aged and Boston University's Gerontology Center concluded that the elderly person living alone, functioned more comfortably and independently when there was an electronic response system in their homes. Lifeline, the system studies by this Group, reduced the need for nursing home care (one day in a nursing home compared to an average of ten nursing home days for a control group during the 14 month study). Long term care costs were also lower due to reduced use of both institutional and community services since each $1 spent for the emergency response system produced a net savings of $7.19 in total long term care costs. (*A Study of the Effects of An Emergency Alarm and Response System for the Aged: A Final Report,* by Sylvia Sherwood, Ph. D. and John Morris, Ph. D., Department of Social Gerontological Research, Hebrew Rehabilitation Center for the Aged, Boston, Massachusetts, February 1980).

### ARMS

Mount Sinai Medical Center, struck with the above-mentioned figures, developed a similar program to reduce the need for institutionalization for the elderly in our service area. Mount Sinai Medical Center extended its "ARMS" to the community through an exciting multi-disciplinary outreach program for the elderly. ARMS (Mount Sinai's Automatic Response Monitoring System) is a personal emergency response system (Lifeline) which provides approximately 200 Community Care for the Elderly recipients throughout Dade County with immediate access to help during a medical emergency. The ARMS program, which is one of the largest hospital sponsored programs in the country, came about when Mount Sinai perceived a special need for an emergency alarm system in the community. In providing this home health service, Mount Sinai was responding to the needs of a primary service area population that is especially skewed in the direction of the upper age group. About 52 percent of the Miami Beach population is over the age of 65, a figure which is overwhelming in light of the lesser Dade County total of 17 percent and the nationwide estimate of 11 percent. South Miami Beach, where the majority of the ARMS program subscribers reside, has a disproportionately large number of elderly, reporting 59 percent of the population over age 65. Mount Sinai Medical Center has, because of its location and because of its position as a voluntary not-for-profit institution, been particularly cognizant of the problems of the aged. Seventy-four (74%)

percent of the patient days at Mount Sinai are for patients over the age of 65 and 48 percent of the patient days are for people 75 years of age and older.

The clients of Mount Sinai's emergency response system are further unique in that they comprise a particularly frail subset of this elderly population. Those eligible for ARMS through Community Care include persons 60 and older (with the average age 78.4) who are homebound, at risk of being placed in a nursing home, and exhibit one of several medical conditions requiring emergency care such as dizziness, falling, and heart conditions (see Table 1).

TABLE 1.—*Disabilities of Subscribers* [1]

| | *Percent* |
|---|---|
| Have had at least one heart attack | 63.0 |
| Have had a stroke | 17.0 |
| Hypertension | 33.0 |
| Arteriosclerosis | 18.5 |
| Diabetes | 37.0 |
| Cancer | 13.0 |
| Blind or visual difficulties | 34.0 |

[1] Does not add up to 100 percent because of multiple disabilities.

A unique element of ARMS is that Mount Sinai has joined the Jewish Community Centers of South Florida and United Community Care in cooperatively planning and managing this personal emergency response system. The array of services these agencies provide, and the measures they have taken to educate ARMS clients, is fundamental to the future success of ARMS. Since all the agencies concerned feel that health care for the aged should include a coordinated approach through health education, prevention, and an array of community services, the presence of ARMS supplements and reinforces this concept.

## GOALS OF ARMS

The planning process of developing the ARMS program required that the three primary agencies delineate the goals of the ARMS program. They are:

To help the elderly and disabled to live independently in their own homes and neighborhoods with the greatest possible security, confidence, and dignity.

To prevent premature or prolonged institutionalization by assuring frail persons and those who are concerned about them that the full range of medical and social services is available at the push of a button.

To establish links and coordinate with existing services so that ARMS becomes part of a comprehensive plan of services.

To reduce the sense of isolation for elderly and disabled community residents by providing immediate access and the accompanying feeling of security that one can get help quickly in case of need.

To connect those who are socially isolated with protective services in case of crime or other environmental stress.

To provide actual or emotional respite for families.

ARMS enables the client to live independently in a community rather than in an institutionalized setting, thereby ensuring an improved quality of life.

## COMPONENTS OF THE SYSTEM

The system has three major components:

Electronic communication equipment in the home which automatically signals for help over existing telephone.

An emergency response center based in Mount Sinai's Emergency Out-Patient departments which offers 24 hour, 7 day a week service, and is responsible for receiving the incoming alarms and sending help when required.

Emergency response organizations such as individuals chosen by the subscriber who have agreed to respond to specific calls for help and/or fire rescue.

The ARMS unit is attached to the telephone and does not interfere with the normal use of the phone. It has the capability of automatically seizing the telephone line, dialing the number of the 24 hour response center and giving identifying information indicating which person is having an emergency. The subscriber can call for help by pressing a button (on a portable pocket size unit) or the ARMS unit can automatically signal for help if the subscriber has been inactive for a specified period of time. Upon receiving an emergency call, the professional staff at the emergency response center (in this case Mount Sinai Medical Center) refers to a subscriber file card which has information about the resident: name, address, phone, medication information, a list of first responders, and the subscriber's personal physician. Immediately, the subscriber is called to confirm the emergency and to get information. If there is no reply, the hospital calls the first responder chosen by the client (a neighbor, or relative, security personnel in an apartment complex or fire rescue) to immediately go to the aid of the user. When the responder arrives, he/she pushes the reset button on the ARMS unit as soon as he/she reaches the subscriber's residence. This causes the unit to send a special "all clear" signal to the response center, indicating that help has arrived. The resident is assisted and, if necessary, fire rescue is called and the patient is brought to the hospital.

### EVALUATION OF ARMS

Mount Sinai Medical Center has just completed an evaluation of ARMS to determine its effectiveness during the period from January, 1981 through March, 1982. Although it was difficult to collect data and analyze trends since the program is in its inception, several discoveries merit observation.

Mount Sinai received an average of 57 calls per month, with a total of 858 calls over a period of 2,338 client months (15 real months). Of these calls, 112 or 13 percent were true emergency calls. The non-emergency calls include failure to use the reset button, failure to switch to "home away" button, machine malfunctions, and accidental activation of the system by the subcriber or someone else (see Table 2).

TABLE 2.—DISTRIBUTION OF ARMS CALLS OVER 15-MONTH PERIOD

[2,338 client months]

| | Number | Percent |
|---|---|---|
| Actual emergency | 112 | 13 |
| Failure to reset | 213 | 25 |
| Pushed machine by mistake | 343 | 40 |
| Machine malfunction | 65 | 8 |
| Other nonemergencies | 93 | 11 |
| "Home Away" buttons not pushed | 32 | 4 |
| Total | 858 | 100 |

There were several differences between ARMS clients and those populations Sherwood and Dibner surveyed. Mount Sinai's clients were older (averaging 78 years to their 71 years and all had to have severe disabilities in order to be considered for ARMS candidacy) and seemed to have more disabilities; yet the most interesting finding concerned the number of social networks and responders to Lifeline clients. Lifeline's survey (A National Survey of Lifeline Programs, Andrew S. Dibner, Ph. D., Lifeline Systems, Waltham, Massachusetts, 1982) revealed that 70 percent of Lifeline's subscribers had three or more responders, while it was discovered that 46 percent of ARMS clients had no first responders and must, therefore, rely on Fire Rescue to be the first responder.

Almost half of the ARMS clients lack "significant others" that make up the social network for a majority of Lifeline clients because they are often resistant to trust neighbors as first responders. Since no screening of false alarms exists through the use of first responders, Fire Rescue must respond to a disproportionate number of false alarms when no other person has access to the client's home to confirm the false alarm. Frequently clients forget to reset their machines at the regularly scheduled intervals. Other times they do not switch on their "home away" button when they leave their apartment. In both instances, the hospital calls the subscribers and, if no one answers, muct assume an emergency situation exists and calls the first responder. In the case of the 46 percent of ARMS clients that have no first responders, Fire Rescue proceed to the subscriber's home to see if an actual emergency is in progress. Fire Rescue frequently breaks down doors and enlists the aid of both the fire department and police only to discover that the client is not home.

In addition to the cost (each fire rescue trip costs a minimum of $211), valuable time which might have been spent in a "real" emergency situation is lost since the number of non-emergency calls was affecting fire rescue's efficiency. The hospital discussed this problem with community care and the Jewish Community Center. It was determined that the clients would have further instruction on the system and be more rigorously evaluated as to whether or not a reset button should be left on the machine. Less than 3 percent of all emergencies are instances where the patient had fallen, was in a medically distressed condition, or had died since last using the phone (Miami Beach Fire/Rescue estimates). Therefore, in instances where there was misuse or abuse of this failure to reset, Community Care determined that the reset button should be removed from the unit if a first responder other than fire rescue did not exist.

When we evaluated the calls received on the system, it closely matched that of the rest of Lifeline clients in that 40 percent of ARMS call's were when the client accidentally pushed the button. This presents no great problem in terms of the efficiency of the system since the receiving station immediately calls the client back and the client responds by indicating that it was triggered by mistake. Failure to reset, which accounts for 25 percent of calls is the greatest problem, unlike other Lifeline systems, because of the lack of first responders.

In general, the ARMS clients have significantly fewer calls per person per month. LIFELINE programs reported approximately one non-emergency signal per month per client, as compared to 32 calls per month per client for ARMS patients. Perhaps the reason ARMS clients have significantly fewer non-emergency calls per month is because they are all Community Care for the Elderly clients and as a result are recipients of many social health and maintenance services. For example, ARMS clients receive the following services along with constant access to and follow-up by Community Care social workers and nurses:

| | *Percent* |
|---|---|
| Meals on wheels | 30 |
| Homemaker/home health | 55 |
| Home Nursing care | 2 |
| Home health aide care | 6 |
| Chore workers | 7 |

### CONCLUSION

The ARMS program has proven to be an important service provided by Community Care for the Elderly. The goal of Community Care is to keep aged, disabled persons out of institutions and to aid them in living independently. An emergency response system gives the client a sense of security in that he/she knows that medical help is close at hand. Because all ARMS clients are Community Care recipients, they are totally tied into a full spectrum of social supports. The receiving station at Mount Sinai Medical Center has easy access to the Community Care coordinator and can refer problems to her immediately and will be assured that action will be taken. Because of this special tie-in, fewer non-emergency calls are received even though almost half of the ARMS clients have no informal support system upon which they can rely.

Although the data collected in this study is limited, all indications point to the fact that the ARMS program aids dramatically in delaying institutionalization of Community Care clients.

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MUNROE REGIONAL MEDICAL CENTER,
*Ocala, Fla., January 26, 1983.*

Hon. ANDREW JACOBS,
*Chairman, Health Subcommittee, House Ways and Means, House of Representatives, Longworth House Office Building, Washington, D.C.*

DEAR REPRESENTATIVE JACOBS: May I take this opportunity to speak for our Auxiliary members, volunteers and hospital staff with reference to "Lifeline" support systems.

It has been our finding that once the Lifeline program was announced and installed in our 22nd home, it has saved many lives.

As I am sure you know, Lifeline is an emergency support system available for the elderly, handicapped, or recently ill who live alone. We have been told by the people who have had Lifeline installed, that they now feel much more secure and are thankful that our Auxiliary made this available to our residents in Marion County.

Most of the users of Lifeline are on limited incomes, often having no additional incomes available for the rental of these units even though we charge only $10 a month.

Our Auxiliary and other civic groups have stepped in whenever needed to help pay that rental.

We would like to ask your support of an amendment of Title XVIII of the Social Security Act to provide medical coverage of personal emergency response services.

Lifeline can never take the place of close family, but many of our users have little or no family and need this type of support system to make the quality of their life better.

We do believe that this is an efficient, long-term care service for many Americans and hope to expand our program to at least 50 local residents.

Sincerely yours,

NANCY J. SCHARMACH,
*Director Community Relations.*

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## STATEMENT OF MAURICE MILLER, PRESIDENT, AND AARON LIBERMAN, EXECUTIVE DIRECTOR, THE NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

Thank you, Mr. Chairman, for giving the National Council of Community Mental Health Centers this opportunity to share our thoughts on the need to expand the range of providers under the Medicare mental health benefit.

The National Council of Community Mental Health Centers represents over 700 community mental health programs throughout the country. These programs provide a variety of mental health services to people of all ages and disability groups. Community mental health programs are designed for short-term treatment with a major emphasis on outpatient and preventive services. Strong prevention and early intervention programs afford a large percentage of people an opportunity to remain in their community at a lower cost than institutionalized care.

In 1982, community mental health programs served approximately 3.5 million people—one-third of the specialty mental health episodes in the United States. Moreover, CMHCs have served an increasing number of patients/clients with serious mental illinesses including schizophrenia and depression. These patients/clients account for 26 percent of all admissions to CMHCs. These efforts to provide needed services to the seriously mentally ill has contributed significantly to the reduction in admission rates to state institutions.

Mr. Chairman, all health care providers and consumers are acutely aware of the ever-rising health care expenditures and we need to develop innovative approaches to deal with this complex problem. In this regard, we believe that community-based mental health services can contribute to the dampening of health care costs. Several research studies have shown that community-based mental health services can have a substantial cost reduction affect on general medical/surgical services as well as inpatient psychiatric care. For example, in Western Pennsylvania, Blue Cross instituted a psychiatric benefit and found that monthly medical/surgical costs per patient was reduced by 50 percent. Moreover, the reduction in the use of medical/surgical services was found to be independent of age, sex, or employment level (Blue Cross of West Pennsylvania, 1976). The findings of the Western Pennsylvania study remain consistent with previous studies conducted in different settings with different demographic samples, and different experimental designs.

A 1978 study conducted by Jameson, Shuman, and Young examined the effect of outpatient psychotherapy in a community mental health center on the utilization and cost of fee-for-service medical treatment. The group that received psychotherapy showed a 57-percent reduction in medical/surgical costs, a 45-percent reduction in inpatient psychiatric costs, and an 80-percent increase in outpatient psychiatric care costs. There was a net reduction of 31 percent of costs per month for each patient. In the comparison group, comprised of 1,340 plan subscribers, no reduction was reported (Jameson, Shuman, Young, 1978).

As you know, Mr. Chairman, the Medicare mental health benefit is very restrictive. There is a $250 annual cap for outpatient services and a 190 lifetime limit on inpatient psychiatric days. Moreover, mental health services must be provided by a physician or under the direct supervision of a physician. The current Medicare mental health benefit promotes the inappropriate utilization of the costlier inpatient health care services. A mental health benefit which would increase access to needed community-based mental health services for older Americans would be an important step in the development of a health care system that provides quality care and is cost-efficient. The National Council of Community Mental Health Centers looks forward to working together with the 98th Congress in order to accomplish these goals.

Thank you, again, Mr. Chairman, for giving us the opportunity to present our views on community-based mental health services.

## STATEMENT OF ARTHUR S. FLEMING, PRESIDENT, NATIONAL COUNCIL ON THE AGING, INC.

I am pleased to present testimony on behalf of the National Council on the Aging to endorse H.R. 6092—a bill introduced by Congressman Fithian to expand Medicare and Medicaid coverage of mental health service providers.

The National Council on the Aging (NCOA), founded in 1950, is the leading national organization for professionals and volunteers, with an across-the-board involvement in all matters affecting the quality of life of older Americans. A nonprofit membership organization, NCOA is a central national resource for research, planning, training, information projects, technical consultation and publications relating to older persons, and is an advocate for improvements in public and private policies concerning older persons. NCOA's membership includes individuals, voluntary agencies and associations (social, health, education, housing, religious, etc.), business organizations and labor unions, all united by a commitment to the principle that the nation's older people are entitled to lives of dignity, security, physical, mental and social well-being and to full participation in society.

The goals of mental health care should include the prevention of mental and emotional problems, and the early intervention and treatment of those problems if they occur. Mental health care should be an important part of the overall effort to enable the elderly to live healthy and independent lives to the greatest extent possible. If institutional care becomes necessary, it must include treatment of mental and emotional disability along with treatment of physical disability.

There are a number of myths and stereotypes commonly applied to older adults. On the one hand, old age is romantically portrayed as a happy, carefree time. Such a notion presumes the impossibility of emotional problems. The reverse myth presents the elder as a wreck of physical and mental deterioration. This negative stereotype implies that senility is a natural state (occurring immediately upon retirement) and that institutionalization is both inevitable and forever. We know both myths to be false.

The elderly do, however, sometimes have problems of a psychological nature, as do younger people. Regardless of age, such problems are often associated with specific events, such as changes in roles or loss of a loved one. Emotional difficulties and dysfunctions caused by such life events are usually treatable and reversible.

However, the mental health service system, which is generally accessible to younger adults, is barely accessible to many older persons. Limitations on accessibility are in large part due to the existing Medicare law, which has established a medically oriented mental health service system and has limited mental health care reimbursement to a sub-minimum level. It is my belief that the Medicare law must be amended in a number of areas to allow older adults the same access to mental health providers and services as is available to the vast majority of younger Americans. H.R. 6092 is an important step toward the accomplishment of this goal, by providing an array of mental health service providers in an open market.

The recent General Accounting Office study "the Elderly Remain in Need of Mental Health Services" notes that:

"The elderly require many of the same mental health services as other age groups. These services include: accurate diagnosis and treatment planning, referral, emergency and crisis management, treatment at the appropriate level in the least restrictive setting, discharge planning, case management for the chronically mentally handicapped, and supportive services."

Yet, the age 65 plus population is conspicuously underserved, particularly in community settings. Only 4 percent of the Community Mental Health Center clients are older people; only 3 percent of all private mental health services are rendered to older clients; and slightly more than 2 percent of the overall Medicare budget is spent on mental health care.

There are a number of factors contributing to the underutilization of mental health services by older adults. The GAO study notes that: "Many of the services which the mentally at risk elderly need are social supports, rather than, or in addition to more traditional mental health interventions." The current Medicare restrictions limiting direct coverage to services provided by psychiatrists and other physicians is too limited, since such providers are less likely to be found in non-traditional settings. On the other hand, psychologists, social workers and mental health nurses are more likely to be in contact with older people in senior centers, nursing homes, home care programs and through other social and health service support systems. This bill, in recognizing the non-medical clinician, will clearly enhance the availability of counselling and other services in the environment of the patient's choice.

I am also pleased that H.R. 6092 will extend recognition of non-medical mental health professionals to the Medicaid program. While many state Medicaid plans already include provision for services by non-physicians, without this bill such coverage will not be available on a national basis. Given the increasing mobility of older people, this provision is important to insure that older people, and particularly the medically indigent are entitled to a uniform choice of service providers, under both Title XVIII and Title XIX of the Social Security Act.

In conclusion, I am pleased to be able to submit testimony in support of this important piece of legislation. In the event that this bill is not passed during the closing session of the 97th Congress, I would urge prompt re-introduction and passage of the bill during the 98th Congress.

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NATIONAL MENTAL HEALTH ASSOCIATION,
*Arlington, Va., January 11, 1983.*

Hon. ANDREW JACOBS, Jr.,
*Chairman, Subcommittee on Health, Ways and Means Committee, U.S. House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: This letter is submitted for the record of the Subcommittee's hearings on HR 6092, a bill to amend Medicare and Medicaid to provide direct reimbursement for services provided by clinical psychologists, clinical social workers, and psychiatric nurses.

The National Mental Health Association is a nationwide, voluntary, non-governmental organization dedicated to the promotion of mental health, the prevention of mental illness, and the improved care and treatment of the mentally ill. Its 850 Chapters and Divisions, and more than one million citizen volunteers, work toward these goals through a wide range of activities in social action, education, advocacy, and information.

The National Mental Health Association has long advocated for improvements in the coverage of mental health care under both Medicare and Medicaid. Medicare, in particular provides extremely poor coverage for mental health services by severely limiting outpatient treatment, failing to cover community mental health centers as providers, and limiting care in a psychiatric hospital to only 190 days in the patient's lifetime. Both Medicare and Medicaid tend to encourage expensive hospital care for mental ill persons, and Medicaid, because of its reimbursement structure, has forced many people into nursing homes, where mental health treatment is often not provided to them.

Our major concerns with Medicare, centers around the benefits available to mentally ill aged and disabled people. The following are the specific problems with Medicare law as it pertains to mental health coverage:

Under Part A, hospital insurance, there is a life-time limit of 190 benefit days in a psychiatric hospital; there is no limit in other hospitals.

Under Part B, supplemental medical insurance, there is a limit on what Medicare will pay for psychiatric services ($250 per annum).

Under Part B, the amount Medicare will pay for the costs of an outpatient session for psychiatric services amounts to 50% of the expected fee; for other illnesses Medicare will pay 80%.

Medicare will not pay for psychiatric day treatment services; a cost-effective alternative to inpatient care.

Medicare will not reimburse community mental health centers as providers under the program, although similar clinics providing physical health care are reimbursed.

H.R. 6092 addresses none of these problems, and therefore, National Mental Health Association cannot support the bill in its current form.

It is the Association's position that the definition of providers who may be directly reimbursed under Title XVIII should be amended so as to cover qualified community mental health centers (CMHCs) and other organized care settings where the patient has access to a team of mental health professionals. Within organized care settings all appropriate services provided by qualified mental health professionals should be reimbursable services. Payment should be made to the organized care setting on a cost related basis, not on a fee for service basis. Appropriate professionals to furnish care in such settings would include the three disciplines defined in HR 6092, but might also include others such as qualified mental health counselors, or psychologists holding a masters degree. Necessary supervision of any professional should be the responsibility of the organized care agency—which itself should meet appropriate standards—and need not be spelled out in federal law.

The National Mental Health Association has taken no formal position on the direction reimbursement of private practitioners deeming it far more critical to secure coverage of organized care settings which provide mental health treatment to all in need regardless of ability to pay. However, with respect to the provisions in HR 6092 concerning direct reimbursement for private solo practioners, National Mental Health Association has some concern over the effect of such reimbursement upon publicly-funded programs, particularly state hospitals and community clinics. When any discipline is reimbursed for solo practice under public and/or private insurance, this can have the effect of draining the supply of such professionals for work in public institutions and community programs.

The choice of private practice with third party funding is one factor which has made it hard for public hospitals and CMHCs to recruit and hold qualified psychiatrists and now in many states qualified psychologists as well. This does not mean expanded coverage of mental health professionals is inappropriate, but it is one important factor to consider when dealing with this type of legislation, particularly a bill like HR 6097 which does not cover CMHCs as providers.

In conclusion, the National Mental Health Association would support legislation which expands outpatient coverage of mental health services, equalizes the copayment asked of mentally ill people, and addresses other discrimination against mentally ill persons.

The National Mental Health Association also supports expansion of Medicare providers to include qualified community programs furnishing mental health treatment. Expanded coverage of mental health professionals in private office settings may be appropriate if these other changes are made, but the Committee should clearly consider the impact of such a change upon public hospitals, CMHCs and other organized community care settings.

Yours for better mental health,

MARION VERNON,
*National President.*

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COUNTY OF ORANGE,
SENIOR CITIZENS ADVISORY COUNCIL,
*Santa Ana, Calif., January 17, 1983.*

Re H.R. 3921 (Emergency Response Systems).

Hon. ANDY JACOBS, Jr.,
*Subcommittee on Health, Committee on Ways and Means,*
*U.S. House of Representatives, Longworth House Office, Washington, D.C.*

DEAR CONGRESSMAN JACOBS: The In-home Supportive Services Committee of the Orange County Senior Citizens Advisory Council, which represents about 300,000 senior citizens, of which approximately 45,000 are classified as frail elderly, wish to add this letter as written testimony to the printed record of the public hearing to examine proposals to provide Medicare coverage for personal emergency response systems.

The In-home Supportive Services Committee has been advocating on behalf of Orange County's senior citizens for the past two years for the availability of personal Emergency Response Systems. Through our efforts, five hospitals have installed base stations for emergency response systems and have made approximately 150 units available to qualified seniors. This is hardly adequate for a population of 45,000 frail elderly and further, many needy frail elderly are unable to afford the service.

The In-home Supportive Services Committee made up of professionals in gerontology and the home health field, and representatives from senior citizen groups, strongly support H.R. 3921. With Medicare coverage for personal emergency response systems, many more isolated and impaired seniors would benefit from this basic protective service. We know that the cost of this in-home support coverage would be off-set in savings from premature institutional placement.

We urge your support of this legislation, which will greatly contribute to the health and welfare of our frail elderly who would be able to remain in their own homes and receive continued support from their neighbors and community.

Sincerely yours,

WILL S. ARMSTRONG,
*Chair, Senior Citizens Advisory Council.*

Our Lady of
Lourdes Memorial Hospital,
*Binghamton, N.Y., January 28, 1983.*

Re medicare reimbursement for personal emergency response services, H.R. 3921.

Hon. Andrew Jacobs,
*Chairman, Health Subcommittee, House Ways and Means,*
*U.S. House of Representatives, Longworth House Office Building, Washington, D.C.*

Dear Mr. Jacobs: In view of your Subcommittee's sincere interest in studying the feasibility of Medicare reimbursement for personal emergency response systems, Our Lady of Lourdes Hospital would like to share its experience with the Lifeline Program.

Lourdes Hospital's Lifeline Program is coordinated through the Emergency Department, and currently involves forty-eight patient-subscribers who purchase the service on a self-pay basis. (More than 200 people have used the service since its inception two years ago.) The subscribers are predominantly frail, disabled, or homebound, and generally live alone or with partial live-in assistance. Referrals for Lifeline service have come from other hospitals, Public Health Department, Office for Aging agency, physicians, and patient-families. The Program has received local commendation as an innovative component of home health care support services in our community.

For 1982, our Lifeline Program averaged just less than one emergency call per subscriber. Of these calls, seventy-seven percent involved accidental falls which required medical assessment, five percent involved suspected cardiac symptoms, and the remainder involved miscellaneous concerns which were addressed by non-medical responders. Of these emergency calls, thirteen percent necessitated hospitalization and acute care treatment.

Since increasing numbers of the frail elderly are being considered for nursing home placement, especially when they live alone, we feel that the Lifeline Service provides a 24-hour monitoring option which likely would delay or prevent nursing home placements. Also, because of our commitment to the Hospice concept of caring for the terminally ill, we have also utilized the Lifeline service to help maintain dying patients at home and minimize their need for hospitalization. In these ways, Lourdes Hospital not only promotes cost effectiveness, but serves to enhance the quality of our patients' lives as well.

If Medicare reimbursement were to be approved, we believe that more people would be able to take advantage of the Lifeline Program. In Broome County alone, there are approximately 2,000 homebound, frail elderly for many institutional placement may have to be considered prematurely unless adequate home care monitoring can be assured.

We appreciate the opportunity to share these comments with you, and commend the Subcommittee's efforts to address the needs of the people we both serve.

Sister Mary Walter Boyle,
*President.*

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Proctor Community Hospital,
*Peoria, Ill., January 19, 1983.*

Hon. Andrew Jacobs,
*Chairman, Health Subcommittee, House Ways and Means,*
*U.S. House of Representatives, Longworth House Office Building, Washington, D.C.*

Dear Sir: As members of your constituency, we would like to request your support for H.R. 3921. This bill would provide Medicare (Part B) reimbursement for Personal Emergency Response Services used by functionally disabled persons in their homes in order to prevent institutionalization.

Medicare reimbursement for Emergency Response Services such as "Lifeline" would not only be cost effective in preventing unnecessary long-term care, but they also may shorten length of stay in acute care facilities. The yearly charge for such a system is approximately the same as one day in the hospital. Each applicant for "Lifeline" is screened to determine the actual need for an Emergency Response System. This screening mechanism would prevent inappropriate utilization that might occur due to Medicare reimbursement.

In the interest of our elderly and disabled persons, the Personal Emergency Response Services enable them to maintain their independent status to prevent sometimes needless institutionalization and can assure continuity of care.

Lifeline is utilized by persons ranging in age from 45-90 to and for the following reasons: 1) various medical conditions, 2) socialization, 3) limitations in physical functioning, and 4) lack of social support systems. It appears that Lifeline has enabled persons to remain in their home environments, preventing early institutionalization.

Lifeline has provided costs savings as related to additional home care services, hospitalization, and nursing home placement.

People can remain in their own homes and do not require the more costly above identified services.

Lifeline does reinforce and make more effective use of the informal support systems of family and friends to the elderly and disabled.

Lifeline is an essential long-term care service and is an integral part of any long-term care delivery system.

Federal reimbursement would enable hospitals to administer more effectively. It has been our experience that elderly and disabled persons on limited incomes have chosen not to utilize Lifeline due to the cost. If Lifeline was a covered service by Medicare/Medicaid, it would enable persons on limited incomes who are in need of Lifeline to obtain this service. The billing procedure would facilitate reimbursement process.

For the above cited reasons that H.R. 3921 should be approved are in order to promote health care cost effectiveness and to provide effectiveness and to provide elderly and disabled persons with an essential long-term service.

Sincerely,

TRULY LAND,
CATHY KRUSE,
DONNA HOLLIDAY,
*Social Service Department.*

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NANCY S. RICHARDSON, LCSW, ACSW,
LICENSED CLINICAL SOCIAL WORKER,
*Alexandria, Va., January 3, 1983.*

Re H.R. 6092.

Hon. ANDY JACOBS,
*Chairman, Subcommittee on Health, Committee on Ways and Means,*
*U.S. House of Representatives, Washington, D.C.*

DEAR MR. JACOBS: As a member of the Greater Washington Society for Clinical Social Work, I am deeply interested in the passage of H.R. 6092.

At present, only physicians, whose services are costly and not always easily available are covered for mental health services through Medicaid and Medicare. Most physicians are not even trained in psychiatry or or psychotherapy.

CHAMPUS recently experimented for a year with using the mental health services of clinical social workers without either referral or supervision by medical doctors. The savings realized by CHAMPUS were in the hundreds of thousands of dollars and the services were found to be effective.

Patients would be benefitted by the provision of, and reimbursement for, services of clinical social workers, psychiatric nurses and clinical psychologists for mental health problems. Many persons avoid going to see a psychiatrist for fear of being labelled "insane". Consequently mental health problems multiply and the person may ultimately have to be institutionalized at high cost to the government.

Equivalent treatment can equally well be provided by properly qualified clinical social workers, psychologists and psychiatric nurses who recognize the need for medication or supervision by psychiatrists in extreme cases, and seek it when necessary.

Needless to say, the higher fees of psychiatrists make treatment by them much more costly to the government. Referral by a physician also imposes an extra and unnecessary layer of cost through fees charged for such a visit.

I urge you to support H.R. 6092 and appreciate your inserting this letter into the permanent record of the Subcommittees hearing on this bill.

Sincerely yours,

NANCY S. RICHARDSON, ACSW.

ST. LUKE'S MEMORIAL HOSPITAL,
*Spokane, Wash., January 24, 1983.*

Hon. ANDREW JACOBS,
*Chairman, Health Subcommitte, House Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C.*

DEAR MR. JACOBS. I represent two hospitals (ST. Luke's Memorial Hospital and Spokane Valley General Hospital) in Spokane, Washington that offer the Lifeline program to the elderly or disabled in our city. I wish to go on record in support of federal legislation amending Medicare, Part B, to include reimbursement for personal emergency response services.

Subscribers to Lifeline are generally elderly people living alone who may have minor health problems but who do not want to go into a nursing home environment. They want to remain independent but need the security of knowing help is available immediately if they need it. Lifeline allows them to keep their independence and not have to pay the high cost of care in a nursing home or institution.

In some cases the health of our Lifeline subscribers has improved because they are not worried about receiving immediate care if they need it—realizing they are just the "push of a button" away from help.

Family and friends of subscribers feel comfortable with the Lifeline program and feel it reinforces their role of support.

Our hospitals use an effective screening system to make sure a person does, indeed, need and would benefit from Lifeline. Thus, an abuse of Medicare funding would not result.

St. Luke's and Valley General Hospitals have offered Lifeline since November 1981, and feel it is an integral part of a long-term delivery system.

Thank you for the opportunity to share in the support of the Lifeline program.

Sincerely,

PRISCILLA L. GILKEY,
*Public Relations Directory, St. Luke's Memorial Hospital/ Spokane Valley General Hospital.*

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STAFF BUILDERS HEALTH CARE SERVICES,
*Indianapolis, Ind., January 20, 1983.*

Hon. ANDREW JACOBS, Jr.,
*House of Representatives,*
*Washington, D.C.*

DEAR MR. JACOBS. In so far as Personal Emergency Response Systems can be utilized effectively by numerous people whose health history requires immediate response, but whose health problems do not necessitate institutionalization, I strongly encourage you to support HR 3931.

Considering the cost of Personal Emergency Response Systems (PERS) as compared to acute or long term placement in a health facility, the cost is almost negligible. I know you are seeking ways to extend the Medicare dollars. I see PERS as a definite advantage. Please consider extending Medicare coverages to PERS (HR, 3931).

Sincerely,

ANITA COBB, RN,
*Director of Health Care Services.*

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THERESE MEDICAL PARK,
ST. THERESE HOSPITAL,
*Waukegan, Ill., January 10, 1983.*

HON. ANDREW JACOBS,
*Chairman, Health Subcommittee, House Ways and Means, House of Representatives, Longworth House Office Building, Washington, D.C.*

Re H.R. 3921.

DEAR CHAIRMAN JACOBS: By means of this letter, I would like to take this opportunity to express the views of St. Therese Hospital in support of H.R. 3921.

Since May, 1982 when we began Lifeline service (we use the acronym, STA-ALERT; ST. Therese Always Alert), twenty persons have been served with this remarkable personal emergency response system.

Sixteen women and four men, including two married couples, all of whom are considered functionally impaired, whose average age is 75, have made appropriate use of Lifeline.

Over ninety per cent of requests received to date are received from anxious children having an elderly parent. This proves that Lifeline reinforces and makes more effective use of family and friends to the elderly and disabled.

Substantial evidence now indicates that use of this personal emergency response system can create an annual health care saving of over $1,500 per person through reduced use of institutional and community health care services.

Surely at a time when there is Congressional reluctance to expand health care services in an era of budgetary restraints, we strongly feel the above facts emphasize Lifeline's ability to save great sums of government money, while providing more appropriate care for the elderly and disabled—in the security of their own homes.

It has often been said and truly so that the ultimate fear the elderly have is not being able to stay in familiar surroundings, their own home.

In many cases of persons inquiring about Lifeline, the elderly person has only Social Security income as their sole financial aid. Unquestionably, federal reimbursement to provide medicare coverage of personal emergency response services would allow hospitals to administer Lifeline more effectively to those persons in financial need.

As a licensed nursing home administrator the past ten years, I am very strongly convinced that Lifeline has become an essential long-term care service, and should be included as an integral part of any long-term care delivery system.

Thank you for allowing me to present the unique contributions of Lifeline to your attention.

Very sincerely,

NORBERT F. GUMBINGER, R.N., FACNHA,
*STA-ALERT Coordinator.*

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SYCAMORE MUNICIPAL HOSPITAL,
*Sycamore, Ill., January 3, 1983.*

Hon. ANDY JACOBS, Jr.,
*Chairman, Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, Longworth House Office, Washington, D.C.*

DEAR CONGRESSMAN JACOBS: This is in regards to the legislation pending that would authorize Medicare coverage for personal emergency response systems, (HR3921).

As a hospital in a rural community, we are very much aware of the elderly patient's needs for immediate care. They prefer their home over a health care setting. In their own home they can be more independent and have a sense of dignity and well being.

In our community we sponsored the Lifeline Program, which is a personal emergency response system. Lifeline has been well received by the Community, and has provided a sense of well being for those participating in the program. While the cost to the patient is minimal (approx. $9.00 per month), each unit cost the hospital $450.00, plus there is the expense of maintenance and other incidentals. If the cost of such a system were covered by Medicare more individuals would avail themselves of the service. In the long run it would help reduce overall hospital costs since there is a tendency for patients who subscribe to such a service to remain at home as opposed to being admitted to a hospital or nursing home.

Sincerely,

MARTIN LOSOFF, *Administrator.*

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